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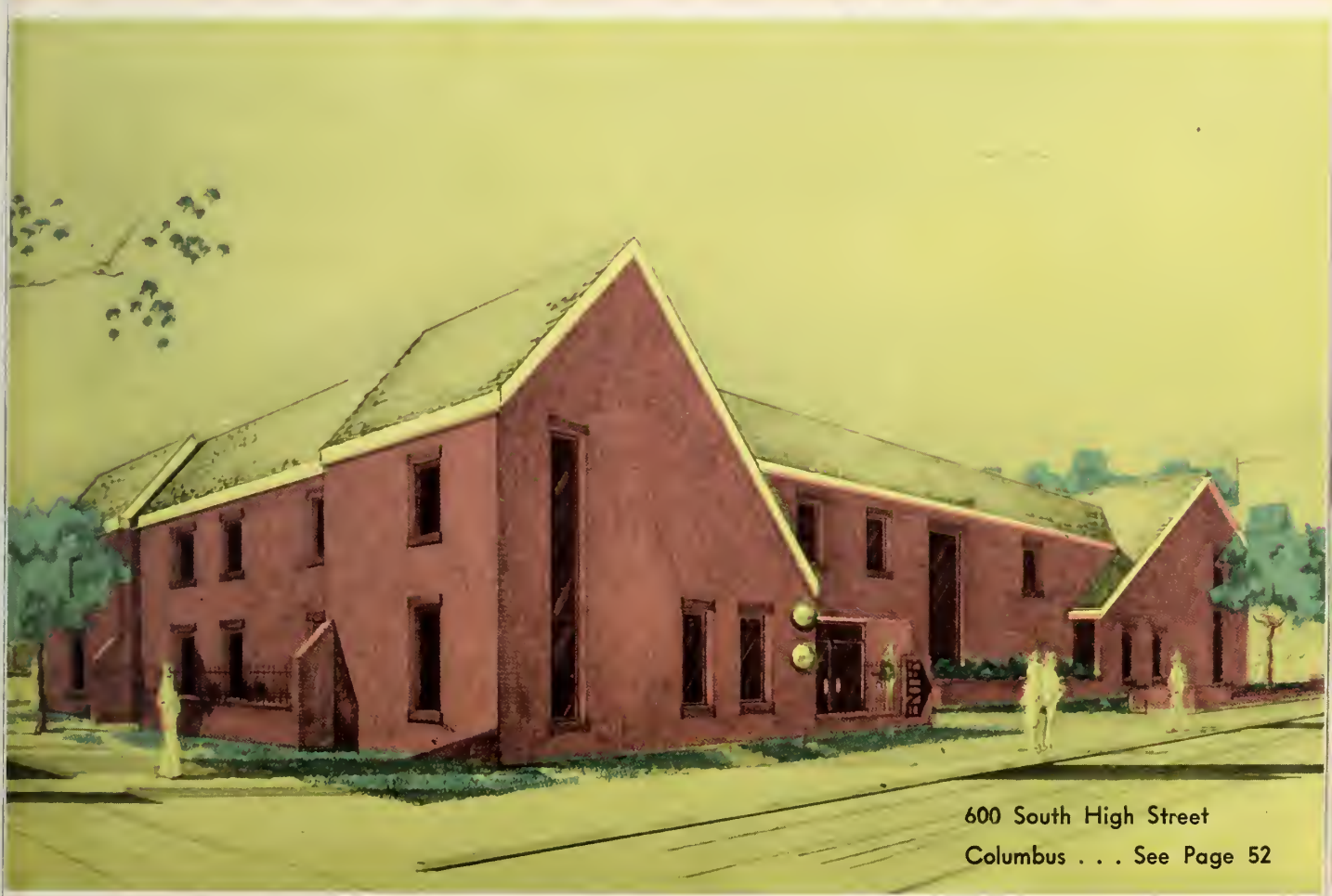
JANUARY • 1974
VOL. 70 NO. 1

The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

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OSMA's *Future Home* . . .



600 South High Street
Columbus . . . See Page 52

Also in This Issue

The Physician, the Minor Patient and the Law . . . Page 4

Awareness of Sickle Cell Abnormalities . . . Page 27

For Index to Other Features Turn to Page 2

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The Ohio State Medical Journal
17 South High Street, Suite 500
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Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

Subscription, $5.00 per year to nonmembers; single copy, 50 cents (outside Continental U.S., $6.50 and 65 cents).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertiser must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

Table of Contents

Page CLINICAL AND SCIENTIFIC FEATURES

27 **Awareness of Sickle Cell Abnormalities. A Medical and Lay Community Problem.** William I. Young, B.S.; Joseph Peters, B.S.; Harold B. Houser, M.D.; and Edgar B. Jackson, Jr., M.D.; Cleveland

31 **A New Look at the Larynx.** Harold C. Klein, M.D., Cleveland.

35 **Clinical Value of Lecithin and Sphingomyelin Determinations in Amniotic Fluid.** E. Damoulaki-Sfakianaki, M.D.; C. de Walt, M.T.; C. R. Macpherson, M.D.; and L. Cordero, M.D.; Columbus.

37 **E.N.T. Case of the Month.** Andrew W. Miglets, Jr., M.D., Columbus.

38 **Coumarin-Related Breast Necrosis. A Case Report and Review of the Literature.** Emmerich von Haam, M.D.; John F. Seidensticker, M.D.; and Glenn E. Hatfield, B.S.; Columbus.

18 Letter to The Editor

SPECIAL ARTICLE

4 Developments In The Law: The Physician and the Minor Patient

PROFESSIONAL ACTIVITIES

46 Matters Discussed and Actions Taken at Nov. 3-4 Meeting of The OSMA Council

51 Portrait Honors Columbus Medical Educator

52 OSMA Headquarters Building Nearing Completion

(CONTINUED ON PAGE 66)



When the allergic patient has a condition requiring an analgesic, a new problem arises. "Idiosyncrasy to salicylates is not rare and is usually manifested by skin rashes and anaphylactoid reaction. Sensitivity to these drugs occurs more frequently in patients with asthma and allergy."[1] Moreover, the previous ingestion of aspirin without ill effects is no guarantee that subsequent use will not precipitate a severe reaction.[2]

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References: 1. Modell, W., ed.: Drugs of Choice 1970-1971. St. Louis, The C. V. Mosby Company, 1970, p. 196. **2.** Goodman, L. S., and Gilman, A., ed.: The Pharmacologic Basis of Therapeutics, ed. 4. New York, The Macmillan Company, 1970, p. 327. **3.** Maslansky, L.: Paper delivered at Fourth International Congress of Allergology. New York, Oct. 18, 1961; abstracted Excerpta Med. Internat. Congress Series, No. 42, p. 124.

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Developments In The Law: The Physician and the Minor Patient

By James E. Pohlman, LL.B.

ONE IDEA "whose time has come" is certainly that the legal age of majority should be lowered from 21 to 18. Perhaps no other idea received such wide-spread acceptance during the early years of this decade. Following the celebrated voting case[1] in which the United States Supreme Court upheld the constitutionality of the provision of the 1970 Federal Voting Right Act granting 18 year olds the right to vote in federal elections, the Twenty-Sixth Amendment incorporating that right into the United State Constitution was promptly passed and ratified by the necessary number of state legislatures. In addition, legislative action in at least 33 states has subsequently declared the age of 18 to be the age of legal adulthood in all respects, not merely for voting purposes. The result of this judicial and legislative activity throughout the country has been to merge the privileges and responsibilities of adulthood for the 18 year old.[2]

Ohio stands in the mainstream of this development. The first regular session of the current 110th General Assembly enacted Senate Bill 1 which became effective on January 1, 1974. Senate Bill 1 amends many sections of the Ohio Revised Code and for all practical purposes makes 18 the age of legal adulthood in Ohio. The most general provision of Senate Bill 1 provides that those age 18 and over are capable of entering into contracts and "are of full age for all purposes."[3]

The newly created status of adulthood for the 18 year old raises several questions for the physician, most notably concerning the consent needed before a physician may properly undertake medical or surgical treatment of a minor. The purpose of this article is to review briefly the law applicable to this issue.

The general rule is that a minor is incapable of giving consent for medical treatment and that such consent must be elicited from a parent or guardian.[4] As of January 1, 1974 the question, "Who is a minor?" must obviously be answered. "One who is under the age of 18." Stated differently, the effect of the enactment of Senate Bill 1 is simply to reduce from 21 to 18 the legal age of majority. Thus, an 18 year old is now capable of giving consent to medical treatment in his or her own right and no further consent of any kind from any other person is necessary.

The enactment of Senate Bill 1 will, therefore, solve many of the consent problems for physicians in situations previously encountered where members of the 18 to 21 year old age group were seeking medical treatment and their parents or guardians were either unavailable or unwilling to give their consent. Parental consent was originally required by the English common law because it was thought that the best interests of both society and persons under 21 were served thereby, the minor being thought to lack the necessary experience, knowledge and maturity. However, the recent trend evidenced by the judicial decisions and legislative enactments noted above is obviously challenging and departing from that thought. A more powerful idea clearly is emerging: Given the nature of today's society, manifested by the behavior of young people, the requirement of parental consent has had a detrimental effect by erecting a barrier between the minor and his receipt of beneficial medical treatment. This trend has resulted not only in the reduction of the age of majority from 21 to 18 for all purposes but also in the recognition and creation of exceptions to the general rule requiring parental consent to medical treatment. In short, the trend of both society and law today is to enable minors to have access to physicians who will be able to treat them without fear of civil liability except for professional negligence.[5]

Although the enactment of Senate Bill 1 effectively solves the physician's consent problem involving the great majority of his young patients, an obvious question remains: May a physician treat a person under the age of 18 without parental consent? The answer is "No" with, however, certain significant exceptions. We shall discuss these exceptions, first those that are statutorily created and next those judicially recognized.

Mr. Pohlman is a Columbus practicing attorney and is legal counsel for the Ohio State Medical Association.

(A) **Statutory exceptions.** The Ohio State Medical Association has sponsored two pieces of legislation in the last two General Assemblies which have resulted in two important exceptions to the general rule. The first statute provides that a minor may give consent to diagnosis and treatment of any venereal disease without the consent of parent or guardian.[6] The second provides that a minor may consent without parental approval to diagnosis or treatment for any condition caused by a drug of abuse.[7] A third statutory exception (narrow in scope but perhaps foreshadowing broader legislation in the near future) permits the minor mother of a dependent child, if such mother is living with the dependent child and receiving welfare aid, to be referred to any private or public agency for family planning information and service.[8]

(B) **Judicial exceptions.** Well before the wave of legislative activity that resulted in lowering the age of majority from 21 to 18, courts were recognizing an exception to the general rule requiring parental consent known as the "mature minor" exception. This exception and its application are well illustrated by one of the leading cases in the country that arose in Cleveland and was ultimately decided by the Ohio Supreme Court.[9]

In that case, an 18-year-old girl after responding to an advertisement in a telephone directory, "Reshape Your Nose, Plastic Surgery," had reconstructive surgery on her nose performed by a "surgeon." (The Supreme Court did not, it is interesting to note, comment upon the ethical questions implicit in the advertisement and did not identify which medical degree, if any, the "surgeon" held.) The girl testified that she told the surgeon's secretary that she was 18; the surgeon testified that she told his office that she was 21. The surgeon was later sued for both assault and battery and malpractice. The case eventually reached the Ohio Supreme Court where the Court divided four to three on the matter of consent that was dispositive of the assault and battery claim. The facts of the case obviously troubled the Court. Writing for the four judges who held that the consent of the parent was not necessary and that, accordingly, the surgeon did not commit an assault and battery upon the plaintiff, Judge (later Chief Justice) Kingsley A. Taft emphasized that the operation was a "simple" one and concluded that the performance of the surgery did not amount to an assault and battery "even though the consent of the girl's parents or guardian (had) not been secured."[10]

Other courts reaching the same result have emphasized that the minor was "intelligent" or "capable."[11] Although the "mature minor" exception is undoubtedly still good law in Ohio, it should be relied upon with caution by physicians in situations involving patients under the age of 18. To put it differently, while the courts first recognized and the legislatures later formalized the idea that persons between the age of 18 and 21 were generally "intelligent" and "capable" and should therefore be given adult status, most courts would probably examine the facts closely in any case of a 17-year-old or 16-year-old patient in which the physician was relying upon the "mature minor" exception to the general rule in order to justify his treatment in the absence of parental consent.

A further judicial exception is found in the cases of "emancipated minors." A minor who is emancipated from parental control or support may effectively consent to medical treatment. Emancipation generally occurs by marriage, judicial decree, consent of the parent, or the failure of the parent or guardian to meet the legal responsibilities of support.[12] Most emancipated youths are in the 18 to 21 age group and these persons, are of course, now adults in Ohio. While some minors under the age of 18 may, in fact, be "emancipated," the physician should probably proceed to treat those persons only if he is satisfied that the minor is living apart from his parents and supporting himself financially.

Lastly, the application to minors of the rule of law that consent in a medical emergency is not required deserves mention. The application of the rule is that the consent of the parent or guardian is applied as a matter of law in those instances where the minor is faced with a life-threatening medical condition. While the burden of establishing a medical emergency rests upon the physician in any subsequent court action, it must also be recognized that a legal **duty** may be placed upon the physician to proceed with medical treatment of a minor in a medical emergency.[13] In short, the physician, should, on both legal and ethical grounds, proceed with medical care in any life-threatening situation involving a minor and assume the burden of establishing later to the satisfaction of a judge or jury that it was in fact a medical emergency. The burden of persuasion will not under those circumstances be difficult to discharge.

One caveat. The physician must bear in mind that, even though the minor under 18 may have the **legal** capacity to give consent to treatment under one or more of the exceptions discussed above, such consent will not fully protect the physician from civil liability unless it is an **informed** consent. While a discussion of the doctrine of "informed consent" is necessarily outside the scope of this article, the following rule of thumb may be suggested — give to the minor patient that explanation of the proposed treatment, its risks and known complications as well as its bene-

(Continued on Page 8)



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lications: Acute gonorrheal urethritis proctitis in the male and acute ganarrheal vicitis and practitis in the female when due usceptible strains af *N. ganorrhoeae.*

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arnings: Nat indicated far the treatment af hilis. Antibiotics used to treat ganarrhea y mask ar delay the symptoms of incubating hilis. Patients shauld be carefully examined manthly serological follow-up for at least anths should be instituted if the diagnosis of syphilis is suspected.
Safety far use in infants, children and pregnant wamen has nat been established.

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fits, which you would want your fellow physician to give your son or daughter of the same age, maturity and capacity under the same or similar circumstances.[14]

In conclusion, the enactment of Senate Bill 1 reducing the legal age of majority to 18 as a practical matter should solve most of the problems formerly facing Ohio physicians in obtaining consent to treatment from persons under 21. For the segment of the population under 18 who seek medical treatment without parental consent, there are certain legally recognized exceptions to the general rule which may be relied upon by the physician in undertaking to discharge his noble goal: the rendition of quality care to persons of all ages.

References

1. *Oregon* v. *Mitchell,* 400 U.S. 112, 27 L. Ed. 2d 272 (1970).
2. Aronoff, What lawyers should know about the new age of majority, XLVI *Ohio Bar,* No. 44 (Nov. 12, 1973).
3. Ohio Revised Code §3109.01.
4. *Medical Malpractice,* page 36 (1973).
5. Wadlington, Minors and health care: the age of consent, 11 *Osgoode Hall Law Journal* 115, 125 (1973).
6. Ohio Revised Code §3709.241, effective July 13, 1971.
7. Ohio Revised Code §3719.012, effective Feb. 9, 1972.
8. Ohio Revised Code §5107.10.
9. *Lacey* v. *Laird,* 166 Ohio St. 12, 139 N.E. 2d. 25 (1956).
10. Ibid, p. 34 of the Northeastern report.
11. See, e.g., *Younts* v. *St. Francis Hospital & School of Nursing, Inc.,* 205 Kan. 292, 469 P. 2d 330 (1970).
12. 41 *O. Jur.* 2d, Parent and child, §26. At least 14 states, but not including Ohio, have enacted broad *statutes* permitting emancipated minors to consent to medical treatment. A more complete discussion is found in Pilpel, Minors' rights to medical care, 36 *Albany Law Review* 462, 464-465 (1972).
13. See, e.g., *Jackovach* v. *Yocum,* 212 Iowa 914, 237 N.W. 444 (1931).
14. The thought that the "Golden Rule" is applicable to the physician's duty to obtain an "informed consent" from his patient is attributable to R. Crawford Morris, Esq., of Cleveland, the noted trial lawyer and expert in medical juris prudence.



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Contraindications: Thyrotoxicosis, acute myoca dial infarction. **Side effects:** The effects of SY THROID (sodium levothyroxine) therapy are slo in being manifested. Side effects, when they occur, are secondary to increased rates of bo metabolism; sweating, heart palpitations wi or without pain, leg cramps, and weight los Diarrhea, vomiting, and nervousness have al been observed. Myxedematous patients wi heart disease have died from abrupt increas in dosage of thyroid drugs. Careful observati of the patient during the beginning of any th roid therapy will alert the physician to any u toward effects.



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1 *Synthroid* is T_4.

2 Because T_4 converts to T_3 at the cellular level, it provides full thyroid replacement at maintenance doses.[1, 2]

3 T_4 hormone content is controlled by chemical assay.

4 *Synthroid* is assayed chemically; no biologic test is necessary to measure potency.

5 *Synthroid* provides predictable results when used with current thyroid function tests.

6 *Synthroid* is the most prescribed brand name of thyroid in the U.S. and Canada.

7 Sodium levothyroxine in *Synthroid* tablets is chemically pure. It does not contain any animal gland parts.

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(sodium levothyroxine)

most cases with side effects, a reduction of ge followed by a more gradual adjustment rd will result in a more accurate indication e patient's dosage requirements without the arance of side effects.

ge and Administration: The activity of mg. SYNTHROID (sodium levothyroxine) ET is equivalent to approximately one grain id, U.S.P. Administer SYNTHROID tablets single daily dose. In hypothyroidism with- nyxedema, the usual initial adult dose is ng. daily, and may be increased by 0.1 mg. 30 days until proper metabolic balance is ned. Clinical evaluation should be made hly and PBI measurements about every 90 . Final maintenance dosage will usually e from 0.2-0.4 mg. daily. In adult myxedema, ng dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyreotic Human Subjects, J. Clin. Invest. 49:855-64, 1970.
2. Surks, M. I., Schadlow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. 51:3104-13, 1972.

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Fits prescribing patterns. CAMA's 10-grain aspirin strength is suited to the higher dosage regimens generally used for arthritis.

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Economical. CAMA costs no more per dose than many 5-grain buffered aspirin tablets. Give your arthritic patients the added benefits of CAMA. Ask your Dorsey representative for a generous supply or write Director of Professional Relations.

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MDs in the News

Dr. William R. Schultz, Wooster, Immediate Past President of the Ohio State Medical Association, was honored by being awarded the College of Wooster's Distinguished Alumni Award. He was cited for his distinguished career and for honor he has brought to the College as an alumnus of the Class of 1933.

He is a Past President of the Wayne County Medical Society; has served on the Board of Governors of the Wooster Community Hospital and as chairman of its Building Committee. He is president of the Wooster Automobile Club, past president of the Rotary Club and is an elder in the Wooster First United Presbyterian Church; also president of the Wooster Board of Education. Other area organizations in which he has played leading roles are the Isaak Walton League, the American Forestry Association, Boys Village, local unit of the American Cancer Society, Wayne County Mental Hygiene Association, Blue Cross of Northeastern Ohio, Elks Club, Chamber of Commerce. He was a member of the College of Wooster's Alumni Board from 1966 to 1969.

Before being named President-Elect of OSMA in 1971, Dr. Schultz served six years as Councilor of the Eleventh District. He has served on numerous OSMA Committees and has traveled extensively in behalf of the Association. At the 1973 Annual Meeting he was named an Alternate Delegate to the American Medical Association.

Also honored at the 14th annual Awards Assembly were Dr. and Mrs. John F. Boyd, of Albuquerque, New Mexico, who were given a joint citation. Both are members of the Wooster Class of 1942.

* * *

Dr. Frank L. Shively, Jr., of Dayton, was elected to the Executive Committee of the American College of Surgeons at the recent annual Clinical Congress held in Chicago. There were over 10,000 physicians registered at the congress and a total attendance of more than 16,000.

There are seven governors of the various regions in Ohio, three of them newly elected to office. They are: Dr. James E. Bennett, Cleveland; Dr. E. Thomas Boles, Jr., Columbus; Dr. F. Miles Flickinger, Lima (new); Dr. Zeph J. R. Hollenbeck, Columbus; Dr. Thomas W. Morgan, Gallipolis (new); Dr. Frank L. Shively, Jr., Dayton; and Dr. George E. Spencer, Jr., Cleveland (new). Dr. Morgan, of Gallipolis, is Ninth District Councilor for the Ohio State Medical Association.

Dr. Howard S. VanOrdstrand, Cleveland, was elevated to the presidency of American College of Chest Physicians at the organization's recent annual scientific assembly in Toronto, Canada. Dr. VanOrdstrand is associated with the Cleveland Clinic and is credited with founding the Department of Pulmonary Diseases there.

He is a past president of the Cleveland Chest Society and of the Ohio Chapter of the American College of Chest Physicians. Among positions of national scope, he has served as consultant to the Surgeon General of the U.S. Air Force, to the Atomic Energy Commission and to the U.S. Public Health Service.

* * *

Dr. Robert M. Zollinger, chairman of long standing for the Department of Surgery at Ohio State University, was honored at a special celebration held recently at the Medical Center and at the Center for Tomorrow on the West Campus. Dr. Zollinger has retired as head of the department, but is maintaining his other affiliations with the College and his practice.

Highlight of the two-day celebration was a banquet sponsored by the Zollinger Club, a group composed of former Zollinger students and colleagues. At this banquet a portrait of the Big Z, painted by the well-known artist Philip Wilson, was unveiled and hung in the College of Medicine hall. Numerous scientific programs were part of the celebration and featured outstanding speakers in medicine and surgery.

Dr. Zollinger has been honored numerous times. He is one of the few physicians who have been president of the American College of Surgeons, president of the American Surgical Association, and chairman of the American Board of Surgery. He also is associated with numerous other professional organizations, is internationally known as a lecturer and author of numerous papers on surgical subjects.

* * *

Dr. Jonathan Forman, Columbus physician and former Editor of *The Journal*, was feted at a recent Fremont banquet and inducted into the Ohio Conservation Hall of Fame for his numerous contributions of time and energy in behalf of national and Ohio conservation.

Continuing Education Opportunities for Physicians in Ohio

January

Ohio State University College of Medicine, Continuing Medical Education Conferences; for details contact OSU Center for Continuing Medical Education, 410 W. Tenth St., Columbus 43210:

Ear, Nose and Throat Disorders — Jan. 31, at Stouffer's University Inn, 3025 Olentangy River Road.

University of Cincinnati College of Medicine (CONMED):

Second Annual Esophagus Symposium — at Jewish Hospital, Cincinnati, Jan. 17.

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106:

Gastrointestinal Surgery — Jan. 16-17.

Medical Progress for Family Physicians — Jan. 30-31.

Family Medicine Review—Sponsored by the Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; at the Sheraton Motor Inn North, 888 E. Granville Rd. (State Route 161 at I-71), Columbus; Jan. 5-6 and Jan. 19-20.

Cleveland Society of Obstetricians and Gynecologists Endocrinology Symposium — at the Shaker House, 3700 Northfield Rd., Shaker Heights, Jan. 16, 3:00 p.m., with dinner at 7:00 and evening session; guest speaker, Nathan Kase, M.D., Chief, Dept. of OB-Gyn, Yale University.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Clinical Problems in Allergy — Akron City Hospital, 525 E. Market St., Akron 44309, Jan. 16.

Practical Clinical Pulmonary Physiology — Sponsored by the American College of Chest Physicians in cooperation with several other organizations at Case Western Reserve University School of Medicine, Cleveland, Jan. 30-Feb. 1. For registration information contact Bradford W. Claxton, M.Ed., American College of Chest Physicians, 112 E. Chestnut St., Chicago, Illinois 60611.

February

Pediatric Workshop — Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214, at Hueston Woods Lodge, College Corner (Southwestern Ohio), Feb. 8-10.

(Continued on Page 16)

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Educational Opportunities in Ohio — *Continued*

Recent Advances in Clinical Psychopharmacology — Sponsored by the Ohio Psychiatric Association, as its Annual Winter Meeting, February 10 at the Marriott Inn, 2124 S. Hamilton Ave., at I-70, Columbus. Gustav A. Batizy, M.D., Program Chairman, 289 Sand Run Road, Akron 44313.

Third Annual Symposium on Clinical Pediatrics, sponsored by Case Western Reserve University, Feb. 12-13. Topic, "Pediatrics, Pragmatism and Pitfalls," includes management problems encountered in medical care of children. Faculty includes Marvin Cornblath, M.D., Frederick Robbins, M.D., and Samuel Gross, M.D., Contact, S. S. Strassman, M.D., Chairman, Pediatric Clinical Faculty, Rainbow-Babies' and Children's Hospital, University Circle, Cleveland 44106.

Common Clinical Problems: Orthopaedic/Neurology — Akron City Hospital, 525 E. Market St., Feb. 20.

Ohio State University College of Medicine, Continuing Medical Education Conferences; for details contact OSU Center for Continuing Medical Education, 410 W. Tenth St., Columbus 43210:

Infectious Diseases — Feb. 6.

Electromyography — Feb. 11-14.

Gastroenterology — Feb. 14-15.

Nutrition — Jan. 19-20.

Orthopaedic Problems — Feb. 27.

University of Cincinnati College of Medicine (CONMED):

University of Cincinnati College of Medicine (CONMED); Contact CONMED, 114 Medical College Bldg., Eden and Bethesda Aves., Cincinnati 45219.

Seminar on Gynecologic Oncology — Thursday, February 7, at the Terrace Hilton Hotel, 15 W. Sixth Street, Cincinnati, in cooperation with Upjohn Company; contact CONMED, 114 Medical College Bldg., Eden and Bethesda Ave., Cincinnati 45219.

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106.

Blood Banking — Feb. 6-7.

Current Concepts in Renal Disease and Hypertension — Feb. 13-14.

Diagnostic and Therapeutic Approach to Rheumatic Disease — Feb. 20-21.

Sports Medicine — Feb. 27-28.

March

Ohio State University College of Medicine; for details contact OSU Center for Continuing Medical Education, 410 W. Tenth Ave., Columbus 43210.

Ophthalmology — March 4-5.

Pediatric Clinic Day — At Children's Hospital, Columbus, March 13.

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106.

Advances in Urology, March 13-14.

Refresher Seminar in Pediatrics for Pediatricians and GPs, March 20-21.

Endocrine Pathology — Anatomic and Clinical, March 27-28.

University of Cincinnati College of Medicine (CONMED); Contact CONMED, 114 Medical College Bldg., Eden and Bethesda Aves., Cincinnati 43219.

Annual VA Hospital Symposium, at the VA Hospital, Cincinnati, March 14.

Ninth Annual Cancer Symposium — Akron City Hospital, 525 E. Market St., March 20-21.

Lederle Symposium — Sponsored in cooperation with the Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214, at the Sheraton-Columbus Motor Hotel in downtown Columbus, March 24.

ABBOTT

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rief Summary

cations—Placidyl (ethchlorvynol) is indicated short-term hypnotic therapy in the management nsomnia.

traindications—Drug hypersensitivity and por-ia.

nings—Not recommended during the first and nd trimester of pregnancy. Caution patients ossible combined exaggerated effects with hol, barbiturates, tranquilizers or other CNS ressants. Exaggerated effects might result in ring of vision, paralysis of accommodation and ound hypnosis. Caution patients concerning ng a motor vehicle, operating machinery, or r hazardous operations requiring alertness af-taking the drug. ADMINISTER WITH CAUTION PATIENTS WITH SUICIDAL TENDENCIES AND NOT PRESCRIBE LARGE QUANTITIES OF THE JG. Adjustment of the dosage of oral anticoag-ts might be necessary when beginning ethchlor-l therapy, during therapy, or after stopping apy. This drug is not recommended for use in dren. PLACIDYL HAS THE POTENTIAL FOR DEVELOPMENT OF PSYCHOLOGICAL AND SICAL DEPENDENCE. INSTANCES OF SE-E WITHDRAWAL SYMPTOMS, INCLUDING NVULSIONS AND DELIRIUM CLINICALLY SIM-R TO THOSE SEEN WITH BARBITURATES, E BEEN REPORTED IN PATIENTS TAKING ULAR DOSES AS LOW AS 1000 MG. PER DAY R A PERIOD OF TIME WHEN THE DRUG WAS DENLY DISCONTINUED. PROLONGED AD-ISTRATION OF THE DRUG IS NOT RECOM-IDED. Addiction-prone patients or those who likely to increase dosages of the drug on their initiative should be observed for evidence of s or symptoms which may indicate possible withdrawal or abstinence symptoms. Signs symptoms associated with withdrawal and ab-nce include unusual anxiety, tremor, ataxia, ing of speech, memory loss, perceptual dis-ns, irritability, agitation and delirium. Other well defined signs and symptoms, not neces-y due to withdrawal and abstinence, may in-e anorexia, nausea or vomiting, weakness, ness, sweating, muscle twitching and weight Abrupt discontinuance of Placidyl following nged overdosage may result in convulsions delirium.

autions—Toxic amblyopia has been reported long-term continuous use of ethchlorvynol. anent visual defects have been observed, al-gh amblyopia has improved after discontinua-of the drug. Drug dosage should be limited lderly and debilitated patients to the smallest tive amount. If pain is present, this drug ld only be given if insomnia persists after is controlled with analgesics. Caution is ad-l in prescribing the drug for patients who are g treated with either MAO inhibitors or anti-essants. Transient delirium has been reported the combination of Placidyl and amitryptyline. dosage should be reduced if prescribed for nts receiving MAO inhibitors or antidepres-s. Caution should be exercised in patients impaired hepatic or renal function. Patients respond unpredictably to barbiturates or alco-or who exhibit excitement and release of inhi-n in association with such agents, may also in this way to Placidyl. Rarely, patients may bit symptoms suggestive of an unusual sus-bility to the drug; such as prolonged hypnosis, ound muscular weakness, excitement, hysteria, ncope without marked hypotension. Transient ness or ataxia may occur.

rse Reactions—Hypotension, nausea or vom-, gastric upset, aftertaste, blurring of vision, ness, facial numbness, and allergic reaction ed by urticaria have been reported following dyl administration. Mild "hangover" and symp-of mild excitation have occurred in some nts. There have been rare reports of cholestatic tice occurring in patients taking ethchlorvynol. w cases of thrombocytopenia have been re-d in patients receiving ethchlorvynol. 306433

Give us his nights.

Prescribe Placidyl. Chances are, we'll give him a good night's sleep.

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September 10, 1973

Editor
The Ohio State Medical Journal

Dear Sir:

I have just read with interest "Little League Sports Programs Another Medical View" in the August 1973 issue (pages 609-610). I believe an important point should be mentioned and stressed since recent studies have tried to determine why pitchers in some little league programs are injured and not so in others. These preliminary studies indicate that injuries to the pre-adolescent in Little League Programs are directly related to pitching in an intensely competitive situation.

Comparison of Little League Baseball programs where (A) one program is highly structured, supervised and where competitive coaches and/or parents are allowed to stress the "Lombardi" win at all costs versus (B) programs where playing baseball is for the sake of recreation rather than competition, indicate that injuries to pitchers are almost nil in the programs stressing recreation. It is interesting that in these leagues pitchers were allowed to curve-ball without restrictions and practice at anytime and still incurred no injuries.

I wholeheartedly agree with Little League Programs but only for the sake of recreation and I would recommend to all interested readers a current article by Joseph Torg, M.D. entitled "Little League; 'The Theft Of A Carefree Youth,'" in the June issue of "The Physician and Sports In Medicine".

Sincerely,
Jerome Burman, M.D.
Gahanna

Hemodialysis Center Slated for Cincinnati VA Hospital

The Veterans Administration will add new hemodialysis centers at its Birmingham and Cincinnati hospitals by June 30, 1974, increasing the capacity of its nationwide kidney machine treatment network by almost 100 patients per year.

Each of the new centers will have from eight to ten beds and an average hemodialysis patient census of from 30 to 45, VA revealed.

The VA network, which now treats about 2,300 patients, consists of 46 dialysis centers, located throughout the agency's medical districts, and 25 smaller satellite or "self-dialysis" units. In addition, sharing arrangements permit veterans to receive treatment at VA expense in some non-federal hospitals.

The agency also has an extensive home dialysis training program, with well over a thousand patients on self-dialysis either in their homes or at satellite facilities.

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IMMEDIATE RELEASE		GRADUAL RELEASE
LIPO-NICIN/100 mg. Each blue tablet contains:	**LIPO-NICIN/250 mg.** Each yellow tablet contains:	**LIPO-NICIN/300 mg.** Each timed-release capsule contains:
Nicotinic Acid ..... 100 mg.	Nicotinic Acid ..... 250 mg.	Nicotinic Acid ..... 300 mg.
Niacinamide ..... 75 mg.	Niacinamide ..... 75 mg.	Ascorbic Acid ..... 150 mg.
Ascorbic Acid ..... 150 mg.	Ascorbic Acid ..... 150 mg.	Thiamine HCL (B-1) .... 25 mg.
Thiamine HCL (B-1) .... 25 mg.	Thiamine HCL (B-1) .... 25 mg.	Riboflavin (B-2) ..... 2 mg.
Riboflavin (B-2) ..... 2 mg.	Riboflavin (B-2) ..... 2 mg.	Pyridoxine HCL (B-6) .. 10 mg.
Pyridoxine HCL (B-6) ... 10 mg.	Pyridoxine HCL (B-6) ... 10 mg.	**DOSE:** 1 to 3 tablets daily.
DOSE: 1 to 5 tablets daily.	**DOSE:** 1 to 3 tablets daily.	**AVAILABLE:** Bottles of 100, 500, 1000
AVAILABLE: Bottles of 100, 500, 1000	**AVAILABLE:** Bottles of 100, 500, 1000	

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

WRITE FOR LITERATURE AND SAMPLES

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INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and $\frac{1}{32}$ oz. (approx.) foil packets.

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Chronic tolerance studies have confirmed the relative safety of Dalm (flurazepam HCl); no depression of cardiac or respiratory func was noted in patients administered recommended or higher d for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldom quired discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. D ness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

sleep for 7 to 8 hou without need to repeat dosage

No sleep m cation has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia pat given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer n time awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to re dosage during the night.

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Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

Dalmane (flurazepam HCl) is a distinctive sleep medication—a odiazepine specifically indicated for insomnia. It is not a barate or methaqualone, nor is it related chemically to any other able hypnotic.

When your evaluation of insomnia indicates the need for a sleep ication, consider Dalmane—a single entity nonnarcotic, nonturate agent proved effective and relatively safe for relief of mnia.

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(flurazepam HCl)
When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep frequent nocturnal awakenings and/or early morning awakening. In patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended

Contraindications: Known hypersensitivity to flurazepam HCl

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants Caution against hazardous occupations requiring complete mental alertness (*e g* , operating machinery, driving) Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards Not recommended for use in persons under 15 years of age Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients Severe sedation lethargy, disorientation and coma probably indicative of drug intolerance or overdosage, have been reported Also reported were headache heartburn, upset stomach, nausea, vomiting, diarrhea, constipation GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints There have also been rare occurrences of sweating, flushes, difficulty in focusing blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT SGPT, total and direct bilirubins and alkaline phosphatase Paradoxical reactions *e g* , excitement, stimulation and hyperactivity, have also been reported in rare instances

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Clinical & Scientific Features



Volume 70 January 1974 Number 1

Awareness of Sickle Cell Abnormalities

A Medical and Lay Community Problem

William I. Young, B.S.; Joseph Peters, B.S.; Harold B. Houser, M.D.; and Edgar B. Jackson, Jr., M.D.

SICKLE CELL ABNORMALITIES are variously estimated to affect 6 to 14 percent of the American black population at birth.[1-3] In the Greater Cleveland area alone, approximately 27,060 blacks are estimated to have sickle cell abnormalities and, of these, approximately 560 are expected to have either classical sickle cell anemia, sickle C disease, or sickle B-thalassemia. These estimates are based on Motulsky's analysis[3] showing AS affecting 8 percent of American blacks, SS, SC, and SB-thalassemia affecting a total of 1.7 American blacks per 1,000. (The black population in Greater Cleveland is 328,000.)

Sickle cell anemia is the most prevalent chronic, serious illness affecting black children,[4] yet there is no cure or established clinical regimen that will arrest the disease. Adequate education and genetic counselling of individuals with sickle cell trait appears to be the best approach to influencing the incidence of this disease at present.

This report describes (1) awareness of sickle cell abnormalities as related to socioeconomic position and age in the black community of a large urban area, and (2) the performance of two university-affiliated pediatric clinics in education, screening, and counselling for sickle cell trait.

Methods

Community Survey: To obtain a representative sample of the socioeconomic spectrum of the black community, a total of 100 black family units were surveyed in three areas of the city: Hough, Lee-Harvard, and Shaker Heights. Census data and the experience of community health investigators were used to select the areas for survey (Table 1).

Two areas, Hough and Lee-Harvard, have a predominantly black population. Family units were selected for interview by starting in the geographic center of the community, then choosing every third house in every other block on odd-numbered streets. If the head of the household was not home, the next third house was selected. The third area, Shaker Heights, has a mixed black and white

This study was completed as a medical student research project funded by the Department of Community Medicine, Case Western Reserve University School of Medicine and The Cleveland Clinic Foundation.

Reprint requests to School of Medicine, Case Western Reserve University, Sears Towers, 2119 Abington Rd., Cleveland, Ohio 44106 (Dr. Jackson).

Submitted July 24, 1973.

population. The highest concentration of blacks resides in the southwestern border of this community. The survey began in this area and subsequent homes were selected by asking black contacts where the nearest black family resided.

All interviews were conducted in the homes by two black medical students during July 1971. Only the responses of heads of households were recorded.

The socioeconomic status of each family unit interviewed was determined by a modification of Hollingshead Index.[5] Because of our sample size, the surveyed population was divided into an upper class consisting of households with position scores of 11 to 33, a middle class with scores of 34 to 56, and a lower class with scores of 57 to 77, instead of the usual seven socioeconomic positions.

Community Group Sessions: Various community groups (religious, social, civic) were informed by letter and mass-media advertisement of our availability to present educational material and to screen for sickle cell abnormalities. Before the presentation, all participants were asked to complete a questionnaire which included demographic information and specific questions related to knowledge of sickle cell anemia. Responses of 78 individuals, 16 to 21 years of age, were analyzed.

Evaluation of Health Care Facilities: The performance of health care facilities in screening, educating, and counselling for sickle cell trait was studied in the general pediatric clinics of two Case Western Reserve University affiliated hospitals (Clinic A and Clinic B). Approximately half the population of each clinic is black. At Clinic A, the charts of all black patients over the age of 7 months with a clinic visit during the month of July 1971 were audited; at Clinic B, a 33 percent random sample of the records of all black patients over the age of 7 months was audited.

Chart audit involved reviewing the entire medical record to determine if a sickle screening test had ever been performed. The parents of children with sickle cell trait were telephoned to determine: (A) if they had ever heard of sickle cell anemia, and (B) if they knew whether or not their child had been screened for sickle cell disorders.

Results

Community Survey and Community Group Sessions: Seventy-six of the 100 households cooperated. The remaining 24 refused to be interviewed. Twenty-three of the refusals occurred in the predominantly middle-class area, Lee-Harvard. One refusal occurred in Shaker Heights, the predominantly upper-class area. The interviewers started in the Lee-Harvard area, and inexperience may have accounted for some of this refusal rate; however, refusals were similar for both interviewers. Many of the noncooperative heads of household refused to admit sickle cell problems existed in their community or simply did not want to be "bothered." Based on the modified Hollingshead position scores, the upper class contained 25 households, the middle class 24, and the lower class 27. The average age of all heads of household was 46 years.

Table 1. Representative Sample of Socioeconomic Spectrum of Blacks in Greater Cleveland Area

Social Class*	Hough	Lee-Harvard	Shaker Heights
Upper (11-33)	0	5	20
Middle (34-55)	4	13	7
Lower (56-77)	19	8	0
Unknown	1	23	0
Total	24	49	27

*Modified Hollingshead Index Score

Table 2. Responses to Questions Concerning Sickle Cell Anemia, According to Socioeconomic Classes and Young Adults

Question		Upper %	Middle %	Lower %	Young Adults %
1. Have you ever heard of sickle cell anemia?	Yes	92	62	33	68
	No	8	38	67	32
2. What type of illness is sickle cell anemia?					
Hereditary		68	24	4	63
Nutritional		4	4	0	1
Contagious		0	0	0	1
Don't know		28	68	96	35
3. Are sickle cell problems common to a particular race?					
Yes		88	56	12	63
No		0	1	0	31
Don't know		12	43	88	6

Table 3. Number of Black Children Receiving Primary Care in Two University Pediatric Clinics During July 1971 Whose Sickle Cell Status Has Been Determined

Sickle Cell Testing		Clinic A	Clinic B
Done	Positive	15	3
	Negative	90	9
	Total	105 (25%)	12 (7%)
Not done		302	153
	Total	407	165

Results of the door-to-door survey are listed by socioeconomic class in Table 2. When these data were classified by education or occupation alone, the results were not significantly different from the analysis by our modified Hollingshead Index. Table 2 also shows the results of the young adults in community group sessions.

Survey of Health Care Facilities: Four-hundred and seven patients' charts were reviewed at Clinic A and 165 charts at Clinic B. The results of this survey are shown in Table 3. Both institutions screened with sodium metabisulfite preparations and confirmed positive screenings with hemoglobin electrophoresis. Fifteen of the 105 (14 percent) children screened at Clinic A, and 3 of the 12 (25

percent) of the children screened at Clinic B had AS hemoglobin. Many of the charts revealed multiple blood tests, hospital admissions, and operations. There was no relationship between the number of sickle cell screening tests and the number of blood tests, hospital admissions, or operations.

Ten of the 18 parents of children with AS hemoblobin were reached by the telephone survey. The children of eight of the respondents were patients at Clinic A and the remaining two at Clinic B. None of these parents had ever heard of sickle cell anemia or knew that their child had been tested.

Discussion

Our data regarding community awareness of sickle cell problems are similar to those of Lane,[6] obtained approximately four years ago. This is indeed discouraging when one considers the increased attention given this problem by the mass media over the past few years. Community awareness must be significantly improved if we are to determine whether education and counselling will influence the incidence of sickle cell anemia. The appallingly low awareness in the lower socioeconomic class demands more than discussion by the mass media if we are to penetrate this group. The differences in understanding by social class suggests that all awareness surveys should include class status if we are to determine the level of community awareness.

It is of interest that more of the young adults in our area seemed to know sickle cell anemia is hereditary, when compared to the average head of a household. However, it is difficult to interpret this because many young adults were unable to give information that would permit classification by the Hollingshead Index, and the sample was not random. Another encouraging note is that most respondents who did not know sickle cell anemia is hereditary were willing to admit their lack of understanding. This suggests that they might be receptive to appropriate educational presentations.

We have recently demonstrated an improvement in education regarding sickle cell problems following a simple presentation. There were 266 tenth-grade biology students tested before and three months after an hour-long presentation on sickle cell problems. The percentage of those who knew sickle cell abnormalities are hereditary increased from 45 percent to 90 percent in this group. (Follow-up studies on adults who were educated, tested, and informed of their test results in various community settings are in progress.) Our experience suggests that a classroom approach with a carefully developed curriculum that includes factual information as well as positive attitudes regarding how one might deal with the information, is a potentially effective long-range measure in expanding community awareness. However, we must reach greater numbers of those in the childbearing age *now*. The most effective means for doing this immediately rests upon providers of health care in institutions and in the private sector. Our data show that physicians in two leading institutions are not significantly involved in education and screening for sickle cell problems.

The reason why two clinics with sizable black populations failed to test and inform individuals regarding sickle cell problems is not clear. Much of the apparent lack of effort in this area has been rationalized by some as: "What good would it do to tell people?" and "They don't want to know anyway." Occasionally physicians admit that they are pessimistic regarding the effectiveness of education in leading to an alteration in health behavior! These physicians cite the fact that consumer education of the causal relationship between cigarette smoking and lung cancer has not caused the majority to stop smoking. Others state that there are mechanisms of denial which most of us have to protect us from perceiving ourselves as experiencing catastrophes; some of these denial mechanisms, which are eloquently described by Kubler-Ross in *On Death and Dying*,[7] may be operative in parents at risk. These denial mechanisms may either minimize the desire of those at risk to be screened, because they won't feel that they can be affected, or may prevent heterozygous pairs from altering their childbearing plans, because they will feel their child would not have sickle cell anemia. Some physicians simply state that education and screening for sickle cell problems takes too much time and is too sensitive an area.

The record audit of institutions described in this report may have led to an improvement in the performance of these institutions. (Both institutions were informed of the findings in the initial study.) A follow-up study showed an increase in performance one year later. Institution A increased

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its test rate of those at risk from 25 percent to 48 percent and institution B from 7 percent to 18 percent. Most parents, whose children had sickle cell trait in the follow-up study, knew their child was positive and had a good idea of what being a carrier meant. Improved parental awareness in the follow-up survey suggests that the improvement in performance was not achieved simply by an edict forcing all bloods that were drawn to be tested, but rather, by providers assuming a more active role in patient education or increased consumer demand for testing. The continued marked difference in rate of testing at the two institutions which serve similar populations suggests the improvement is due to alteration of provider behavior.

Improved community education and access to testing and sensitive counselling might diminish the incidence of sickle cell anemia and certainly might decrease the number of families with multiple children with sickle cell anemia. Three local pediatricians in private practice have identified 16 heterozygous pairs (both parents AS) by routine screening of children and their parents over the past five years. All but two of these couples had at least one child with sickle cell anemia before they knew of their carrier state. Almost all of these parents decided not to have further children. The decision not to have further children once the burden is understood is not unexpected. Carter has reported that parents whose offspring are at risk of serious abnormalities tend not to have further children—especially if that risk is greater than 10 percent.[8] However, the troublesome issue of whether a couple's knowledge of the risk of having a child with sickle cell anemia prior to childbearing would alter their plans for family size is unsettled. Childs, et al, state that awareness of burden is the greatest determinant of the effectiveness of genetic counselling.[9] One might expect that if the burden of sickle cell anemia is teachable, prior to a couple's having a child with the illness, counseling would be effective in heterozygous couples prior to childbearing. A more basic issue, and one that is easily resolved, is the responsibility of providers to share with consumers information that affects their health. Our challenge then, is to develop effective ways to teach the facts of sickle cell anemia to all sectors of the susceptible community, to assure facilities for those who want to be tested, to provide sensitive genetic counselling for those found to be carriers, and to provide improved facilities for those found to have sickle cell anemia.

We encourage all health providers to become involved in educating and testing individuals at risk of having a child with sickle cell anemia. We suggest that other institutions use medical record audit and feedback to physicians to improve education and screening for sickle cell trait. We further suggest that screening be done by hemoglobin electrophoresis (to detect nonsickling but significant interacting hemoglobinopathies, eg, AC and AD), and that counsellors arm carriers with facts but not coerce them to alter childbearing patterns. We urge only one caution, that screening and counselling be done in a fashion that will allow determination of outcome—its effect on childbearing of heterozygous pairs and its potentially harmful psychological effects on all who are carriers.

Summary

This report demonstrates a low level of awareness of sickle cell problems in all sectors of the black community of a large urban area, in spite of the increased attention given sickle cell anemia in the news media. Awareness is particularly low in the lower socioeconomic group.

Levels of awareness are relatively easily improved in a classroom setting with high school biology students.

Some local practitioners have had experiences which suggest it would be helpful to educate and screen individuals at risk of sickle cell abnormalities. Two institutions with sizable black populations had poor performances in educating and screening those at risk, but showed improvement after audit and feedback of their performance.

There should be an increase in critical studies that will allow us to: (A) determine the most effective ways to educate all sectors of the susceptible community about sickle cell problems and get maximal participation with voluntary testing, and (B) determine the outcome of testing and counselling, its favorable effects as well as its potentially harmful psychological effects.

In addition, we hope there will be increased effort to find ways to effectively treat or cure sickle cell anemia.

Acknowledgments: We acknowledge the guidance and continued interest of John W. Harris, M.D., and the Greater Cleveland Sickle Cell Medical Advisory Committee, and the technical assistance of Mr. Vincent Bell, Miss Mary Davies, and Mr. Joe Hargrove.

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A New Look at the Larynx

Harold C. Klein, M.D.

THE LARYNX has become a skeleton in the closet of our medical family, hidden away, shrugged off, and woefully neglected. Its shape can be seen in the neck and its outlines felt in the course of a physical examination, but in its tantalizing position, just barely beyond the reach of the examining eye, we sidle past it as though it doesn't exist. This studied neglect is not because we are unaware of the importance of the larynx as a functioning organ and as a site of disease. Physiologically, it is a wind instrument on which the whole range of sound necessary for tonal communication can be orchestrated. Anatomically, it sits astride the portals of the respiratory apparatus and is bathed in a constant flow of airborne irritants and pollutants.

In our cancer literature and educational material, the phrase, "early detection" is all too familiar. In this regard, the urgency and importance of routinely viewing the larynx is tersely brought to our attention by Lederman,[1] who states: "Early cancer of the larynx is one of the most benign and easily curable cancers that affect the body; yet if these same tumors are allowed to progress either through neglect or failure in diagnosis, neither modern radiotherapy nor even the most ultra-radical surgery will save the patient." The American Cancer Society in its publication, *Cancer Facts and Figures for 1972,* estimates that approximately 7,000 new cases of laryngeal cancer will be discovered this year, to say nothing of the nonmalignant and premalignant lesions. They also estimate 3,000 deaths during the year from cancer of the larynx. As a protective measure to safeguard against such figures, they suggest, "annual checkup, including mirror laryngoscopy" and add the very important comment, "readily curable if caught early."

Submitted July 18, 1973.

The Author

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The medical check-up or complete examination is a ceremonial rite, methodically exercised in clinics, private offices, and hospital wards. Some are done in response to symptoms while others are performed as a routine periodic procedure to ferret out unsuspected disease, the so-called early detection program. The term "complete examination" connotes uniformity and implies the turning of every stone. How truly complete such an examination may be depends on the examiner's concepts regarding the relative importance of such ancillary measures as routine sigmoidoscopy, Pap smears, x-ray films of the chest, a bevy of laboratory tests, and even barium studies of the gastrointestinal tract. Unfortunately, viewing the larynx, which should be an essential of every examination, is usually ignored. A clinic or medical group may assign an otolaryngologist to perform this function, but the practitioner will, by and large, systematically check the eyes, ears, nose, and throat, palpate the neck, and simply by-pass the larynx as though a page had been torn from the manual of examination procedure. The knowledge that laryngeal lesions when found early respond well to treatment, that early lesions may be present without symptoms, and that patients frequently fail to re-

port recurrent hoarseness or voice fatigue in their histories, all tend to emphasize unquestionably the necessity for viewing this organ as part of a routine.

It is a teasing thought that the larynx can escape easy viewing when it sits just a few centimeters away from sight, hidden below and behind the tongue. To compound the frustration, it is delicately and devilishly guarded against instrumentation by the sensitive gag reflex of the oropharynx. To circumvent this difficulty, the familiar angled mirror has been used for over 100 years. It is a technic that requires patience and expertise, and in the hands of the specialist who has been trained in the method, mirror laryngoscopy is a simple and usually adequate procedure. To the practitioner, however, the problems involved in arranging his light and his line of vision, warming and manipulating the mirror, positioning and cajoling the patient—only to fail or get just a fleeting glimpse of the larynx—are more than his schedule or patience will tolerate. After a few such frustrating attempts, he stores the mirror in a drawer and quietly abandons the procedure. He salves his conscience with the silent resolve to promptly refer any suspicious problem to the specialist.

Recognizing the failure of the mirror to fill the need for a simple routine viewing of the larynx, other methods have been explored. Since the challenge involves looking around a corner, the use of a right-angled telescope with a built-in light source was an obvious possibility. It would appear rather simple to pass a suitable telescope through the mouth and when the objective lens enters the oropharyngeal space, to get a good view of the larynx. Many such instruments have been made available in the past but they have not met with any measure of acceptance because of the inability to hold the telescope by its eyepiece end and, at the same time, keep the objective end rigidly still. Not only does the moving objective fail to provide a clear view, but the motion serves to trigger the gag reflex. The examiner, therefore, finds himself in the impossible position of needing one hand to hold the tongue, one to hold the instrument and to guide it forward through the mouth, and a third hand to steady the tube.

To obviate this deficiency, a holder was designed to fit on the thumb of the tongue-holding hand. Attached to the proximal phalanx, it leaves the distal phalanx free to grasp the tongue. The holder is channeled to cradle the instrument and hold it firmly in position. In effect, such a holder permits the use of one hand for two purposes, holding the tongue and steadying the telescope to keep it from wobbling. The other hand is then



Position of viewer and holder during examination. Visualized field (inset).

free to introduce the instrument into the holder and guide it forward through the mouth. Given this control, it frequently is possible to pass the instrument in such a manner that contact with the pharynx is avoided and the gag reflex is not initiated.

After experimenting with various types of right-angled telescopes, the following criteria were formulated. The instrument must be of small diameter, structurally sturdy, and have adequate illumination. The lens and prism system must afford a clear, bright image of the larynx in its normal position rather than juxtaposed as it is with the mirror. Finally, to afford universal availability, it should be producible at a relatively small cost. An instrument that fulfilled these criteria was produced by the engineers of Statham Instruments, Incorporated and a feasibility study was undertaken.

Purpose

To determine if effective viewing of the larynx as a routine procedure in the course of a physical examination could be accomplished easily and quickly with this instrument.

Material

The viewer is a specially designed right-angle telescope with standard illumination provided by a 6-volt power source. The thumb holder and technic are illustrated in the figure.

The patients were completely unchosen. They were all from the author's day-to-day private practice of internal medicine encompassing a wide range of diseases, ages, and economic backgrounds. Laryngeal viewing was made a routine part of the complete examination of every patient regardless of symptoms or diagnosis. They were given no particular explanation and were not made aware of being part of a study.

Method

At a convenient time in the examination, the patient is seated on the examining table, the instrument is connected to its electrical source, and the lights are dimmed. The subject is instructed to open his mouth wide, extend his tongue, and breath gently through his mouth. With the holder in place on the examiner's thumb, the tongue is grasped, the instrument introduced and guided gently under direct vision through the mouth. When the objective end is seen to be entering the pharynx, viewing through the ocular is started and the patient is instructed to say "E." At this point, the base of the tongue and epiglottis are clearly seen. As the patient continues to phonate, the instrument is glided forward until the larynx comes to view. It can be clearly and beautifully seen. Care must be exercised to insert the instrument far enough to view the anterior commissure. The vocal cords and surrounding tissues are then examined in the open and closed positions and the instrument is removed. On occasion, the patient is asked to remove dentures if they are ill-fitted and tend to fall when the mouth is kept open.

In no cases were anesthetic sprays used to deaden the gag reflex.

Measuring the time necessary to complete the examination, we found it was generally accomplished in approximately one minute. If the patient gagged or fussed so that too much time was required for the purposes of this study, it was considered an unsuccessful "routine" viewing.

Study

In a group of 500 consecutive unselected patients on whom complete physical examinations were performed, laryngeal viewing by our technic was included in the routine. Collected data included the age and sex of each patient, the quality of the view, the degree of gagging, and the diagnosis. For the purpose of this study, the quality of the view was graded from zero to four plus as follows:

0	No view. Unsuccessful examination.
+	A glimpse of the larynx, considered inadequate for diagnosis.
++	Minimal but adequate view.
+++	Complete viewing with only minimal restriction.
++++	Excellent viewing.

Gagging also was rated on a scale of zero to four plus:

0	None
+	Minimal
++	Minor, with little or no encumbrance to the examiner.
+++	Moderately severe and enough to limit the examination.
++++	Severe with retching. Examination impossible.

There were 282 females and 218 males. The ages ranged from 15 to 85 years.

Results

Quality of View		Gag	
++++	311 patients	0	322 patients
+++	106 patients	+	74 patients
++	57 patients	++	58 patients
+	15 patients	+++	36 patients
0	11 patients	++++	10 patients

Of the 474 successful viewings, the larynx was normal in 383 patients. Some degree of abnormali-

ty from benign to malignant polyp, nodules, keratosis, edema, inflammation, and others, was found in the remaining 91 patients. It is of interest to note that at times, a relatively normal larynx was found in some patients who were chronically hoarse, whereas, disease was noted in some where there were no symptoms. Other asymptomatic conditions, such as epiglottic cysts and false cord tumors, were also seen.

Conclusions

It is possible for any physician to perform laryngoscopy as part of routine physical examination. It can be done simply, quickly, and without anesthesia. In our study, in the hands of an internist, the larynx was successfully viewed in 474 out of 500 attempts (94.8 percent). Of the 16 failures, one was because of arthritis of the neck, two because of a scarred, fixed epiglottis that obscured the cords, and one because of a mouth too small to accept even our instrument. The remaining 12 failures were due to extreme gagging.

Discussion

No discussion of laryngeal viewing would be complete without some mention of the problem of gagging. The otolaryngologist is well acquainted with the patient who starts to gag and retch at the very prospect of instrumentation. In these people, the larynx can only be examined under anesthesia in an operating room. In our series, there were ten 4-plus gaggers and, of course, they were failures. On the other hand, it was noted that with many tense individuals in whom failure might be predicted, the examination proceeded smoothly and without gagging. Even with the people who initially protested that they gagged easily and always gave their dentist a hard time, little or no problem was encountered with our method. Mild gagging was usually overcome with soft reassurance. We had the feeling that some gagging was brought on by the patient's fear that the instrument was going to be pushed down into the throat. We found that repeat examinations, months or a year later when the patient was familiar with the procedure, were extremely well-received and often with little or no gag. In the patients who had mirror laryngoscopy in the past, our method was invariably preferred and deemed much easier to take.

As noted in every laryngoscopy practice, a good proportion of patients will gag on any attempted instrumentation and thereby foil a thorough viewing. Even in the face of some gagging, the asymptomatic larynx can be glimpsed adequately to assure its normalcy. If the level of suspicion is high enough and the view inadequate, the physician should refer this patient to the specialist for examination under local or general anesthesia.

In this paper, we mentioned that one of the criteria for this instrument was that it be sturdy enough to withstand repeated daily usage without failure. Our standard viewer was used in well over 1,000 examinations without trouble. Even the original bulb is still in use.

Sterilization is accomplished simply by a vigorous wipe with a soaked alcohol sponge. The holder is made of a heat-resilient plastic that can withstand boiling if so desired.

The instrument was introduced to a group of physicians including an otolaryngologist, a radiologist, internists, residents, and interns. Without prior training, none of them experienced difficulty in seeing the larynx in most of the patients they examined. In the opinion of the otolaryngologist, the view was equivalent to that obtained with his #5 mirror. Some of the house staff group confessed that they had really seen a larynx for the first time in their medical careers. The radiologist saw in the instrument an excellent tool for the follow-up of cancer-treated patients. In effect, the instrument permitted the novice to see the larynx as often and as clearly as the specialist trained in the mirror technic.

In one case, a foreign body was missed on "thorough" examination in a hospital emergency room. By using the laryngeal viewer, a fish bone was clearly seen projecting from a crypt of the lingual tonsil.

No instrument can replace the experience of the specialist. This instrument can only afford the nonspecialist the opportunity of seeing the larynx so that an abnormality can be found early and referred to the specialist for definitive diagnosis and early care.

Summary

An instrument was developed which will permit any physician to view the larynx simply, quickly, and without preparation either as part of a routine physical examination or in the investigation of symptoms referrable to the larynx. It is proposed as a means for the early detection of lesions in a hitherto neglected area for their prompt referral to the attention of the specialist for therapy.

Acknowledgments: I appreciate the guidance, advice, and support of Walter H. Maloney, M.D., Director, Division of Otolaryngology, University Hospitals, Case Western Reserve University School of Medicine; and Mr. Leroy Johnson, Manager, Electrosurgical and Optical Products Division, Statham Instruments, Inc., Oxnard, Calif.

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Clinical Value of Lecithin and Sphingomyelin Determinations in Amniotic Fluid

E. Damoulaki-Sfakianaki, M.D.; C. de Walt, M.T.; C. R. Macpherson, M.D.; and L. Cordero, M.D.

PREMATURE BIRTH is firmly established as the leading factor associated with increased morbidity and severe sequelae in later life.[1,2] Most of the fatalities are due to Respiratory Distress Syndrome (RDS) and probably account for 25,000 per year in the United States.

Normal respiratory function in the newborn depends on the development in utero of enough surfactant in the alveolar lining to insure alveolar stability during respiration.[4,5] This surface-active material contains a high proportion of phospholipids, mainly lecithin.[6] It is accepted that the phospholipids (particular lecithin) appearing in amniotic fluid originate principally from the fetal lung.[7]

Changes in the amniotic fluid phospholipids observed at different stages of gestation have been shown to reflect those which occur in the fetal lung.[7] In serial amniotic fluid samples, the relationship of lecithin and sphingomyelin (L/S ratio) changes as gestation advances. Until about the 30th week of gestation, the concentration of sphingomyelin in amniotic fluid usually is equal to or higher than that of lecithin. From then on, lecithin concentration rises slowly until the 35th week, when it increases sharply (usually to more than twice that of sphingomyelin). The changes in the ratio of the two phospholipids suggest that pulmonary maturity has advanced to the stage that permits extra-uterine life to proceed normally.

This paper reports our experience with lecithin and sphingomyelin determinations in amniotic fluid for evaluation of pulmonary maturity as reflected by the incidence and severity of RDS in the newborn.

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This study was partially supported by Division of Maternal and Child Health, State of Ohio (MCH/27-RF 2052G).

Submitted June 22, 1973.

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• Dr. Cordero, Columbus, is Director, Department of Pediatrics, Division of Neonatology, The Ohio State University Hospitals; and Associate Professor, Department of Pediatrics, The Ohio State University College of Medicine.

Patients and Methods

Three hundred and seven amniotic fluid specimens obtained by transabdominal amniocentesis from 146 women were studied. All samples contaminated with blood and/or meconium were discarded and only 237 specimens were analyzed. The amniocenteses were indicated for diagnosis and follow-up of Rhesus isoimmunization (57 patients,

none of whom received intra-uterine transfusions [146 samples]). Serial samples were obtained at different stages of gestation from 59 women (150 samples) while the remaining of the group provided a single fluid specimen. Lecithin and sphingomyelin determinations in the amniotic fluid were done by thin-layer chromatography as described by Gluck, et al.[7] The only modification of that method was the exposure of the plates to iodine vapors for better visualization of the lecithin and sphingomyelin spots. Optical density,[8] creatinine content,[9] and percentage of fat cells[10] in the amniotic fluid also were studied.

Results

Lecithin and sphingomyelin levels in amniotic fluid samples at different stages of gestation are shown. (See graph.) An increasing trend in L/S ratio values is seen throughout pregnancy, but it is important to note that ratios of 2.0 or lower persisted until the 33rd week of gestation. At any given week of gestation, the sizable standard error of the mean demonstrates a remarkable individual variability not attributable to the methodology employed.[11] Gestational age taken from maternal menstrual history was correlated with creatinine values ($n = 233$, $r = 0.89$, $p\ 0.001$), percentage of fat cells ($n = 209$, $r = 0.53$, $p\ 0.001$), and with L/S ratio ($n = 237$, $r = 0.68$, $p\ 0.001$). Unlike gestational age, birth weight of the infants correlated poorly with L/S ratios.

One hundred and fifteen infants whose mothers underwent amniocentesis within two weeks of delivery were available for follow-up. Morbidity and mortality due to RDS were the criteria for the prognostic significance of the L/S ratio values (Table). It can be seen that, in our laboratories, ratios of 1.0 carried the largest and most severe complications while ratios equal to or greater than 3.0 were compatible with a good pulmonary function.

Predelivery Amniotic Fluid L/S Ratios and Outcome in 115 Pregnancies.

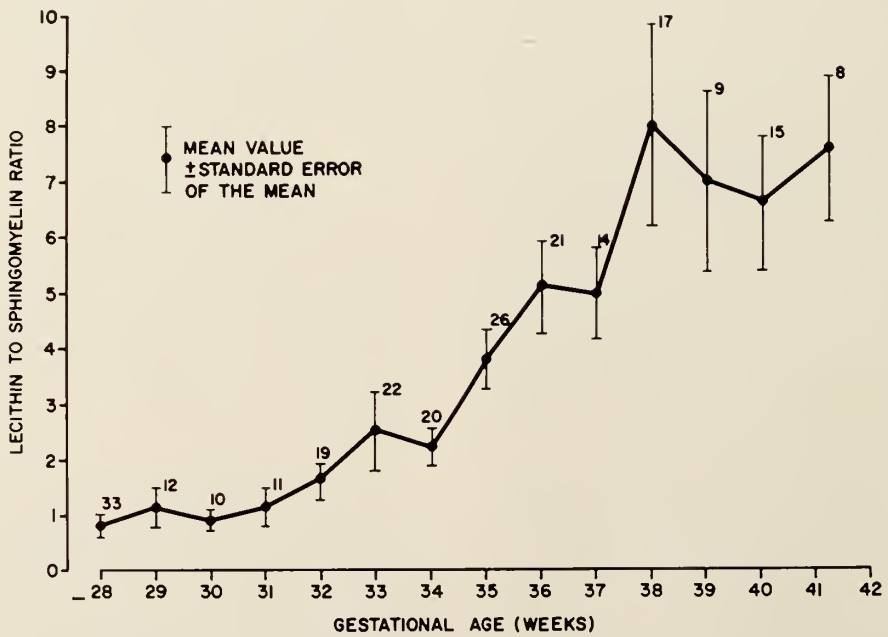
Lecithin Sphingomyelin Ratio	Respiratory Distress Syndrome None	Mild*	Severe†
1/1	12	1	2
2/1	13	1	0
≥ 3/1	85	1	0
Total	110	3	2

*Mild respiratory difficulty, no evidence of severe respiratory and/or metabolic acidosis with full recovery within 72 hours.

†Respiratory failure requiring artificial ventilation. Both infants were born at 33 weeks of gestation and did not experience hypothermia or acidosis prior to onset of disease.

Discussion

Termination of pregnancy before term, prior to the onset of labor, is frequently indicated in pregnancies complicated by erythroblastosis fetalis, toxemia, maternal diabetes, placental insufficiency, and other complications. The advantages gained from termination of pregnancy must be weighed accurately against the risks of prematurity. Estimation of fetal maturity by menstrual history, clinical



Mean and standard error of mean of L/S ratio at different stages of gestation. Figures over dots show number of samples analyzed.

and x-ray evaluation and even cephalometry is not always practical and accurate. Different determinations in amniotic fluid samples have been recently used more successfully.[7-10] The determination of lecithin-to-sphingomyelin ratio in amniotic fluid, as described by Gluck, et al,[7] is the method used in this study. The procedure is simple, requires only basic thin-layer chromatography technics, and can be completed in 1½ to 2 hours. Unlike others, we have found it very hard to estimate ratios 1.1, 1.2, 1.3, and others even using the densitometer. Therefore, we decided to express the ratios as whole numbers (1.0, 2.0, 3.0). In our hands, the method has been useful to identify the population at risk and to anticipate the severity of neonatal RDS.

A ratio of 1.0 or less was associated with the highest morbidity and mortality, a ratio of 2.0 was associated with 7 percent chances of developing RDS, while a ratio of 3.0 or more was an indication of pulmonary maturity with no likelihood of development of RDS after birth.

Summary

Lecithin-to-sphingomyelin determinations were performed on 237 amniotic fluid samples taken from 146 pregnant women. Thin-layer chromatography was used in the identification of the phospholipids and the ratios were determined with the densitometer. L/S ratios correlated poorly with birth weight but correlated strongly with gestational age obtained by maternal history. One hundred and fifteen infants born within two weeks of the last amniocentesis were observed for signs of RDS after birth and it was found that 3 out of 15 infants with an L/S ratio of 1.0 or less developed RDS (two of them severe, one died), 1 out of 13 infants with an L/S ratio of 3.0 or more developed mild transient tachypnea of the newborn, which lasted only a few hours. It is concluded that the L/S ratio determination in amniotic fluid is very useful clinically and is a good index of fetal lung maturity.

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E.N.T. Case of the Month

Andrew W. Miglets, Jr., M.D.*

A 56-year-old man enters your office with a "sore" which has been present under his tongue for the past six weeks. (See figure.) Physical examination reveals an ulcerative lesion present on the middle one-third of his tongue. A 2 × 2 cm firm node was palpated along the anterior border of his right sternocleidomastoid muscle. The node is painless and freely movable.

What is the most probable diagnosis and how should it be evaluated?

(See p. 43 of this issue for further information and discussion.)



This small ulcer has been present for at least six weeks.

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Submitted August 2, 1973.

Coumarin-Related Breast Necrosis

A Case Report and Review of the Literature

Emmerich von Haam, M.D.; John F. Seidensticker, M.D.; and Glenn E. Hatfield, B.S.

ORAL ANTICOAGULANTS have caused hemorrhagic complications in a wide variety of tissues since the introduction of coumarin 30 years ago. Flood and his co-workers, in 1943, reported the first case in which necrosis of the female breast occurred after treatment with bishydroxycoumarin.[1] Since 1943, a few other sporadic cases, predominantly in the European literature, have been reported in which the female breast was the site of involvement in coumarin-related tissue necrosis. Several theories have been proposed, but the exact pathogenesis of the disease remains a mystery. This paper is a report of one such case and a review of the literature.

Case Report

A 65-year-old white woman was hospitalized with a two-day history of right-sided, pleural-type chest pain and increasing dyspnea. This had been preceded by a three-week history of pain, discoloration, and swelling of the left leg. Physical examination revealed a temperature of 39.4 C, tachycardia, and dullness in the basilar area of the right lung with a few rales. A diagnosis of pulmonary emboli secondary to thrombophlebitis was made. Chest roentgenogram was compatible with pulmonary infarction and lung scan revealed involvement of areas in the upper medial and lower right lung.

Intravenous heparin therapy was then initiated and continued for the first seven hospital days, when decreasing doses of subcutaneously administered heparin were substituted. Thirty mg of coumadin was given orally on the seventh hospital day and 20 mg was given on the eighth hospital day. No coumadin was administered thereafter, as the prothrombin time was 29 seconds with a control of 13 seconds on the ninth hospital day. On the tenth hospital day, the patient experienced the onset of pain in the left breast. Examination revealed a large area of black discoloration on the lateral aspect of the left breast with a surrounding erythematous ring. There were no masses, no evidence of infection, and no history of trauma. Subcutaneous heparin was discontinued. Prothrombin time was 27 seconds. Over the next three days, prothrombin times were 32, 29, and 31 seconds. During the next ten days, the area of involvement enlarged, involving the left chest wall and most of the breast. This entire area gradually became necrotic (Figs. 1 and 2).

Varidase therapy was begun on the 11th hospital day, and intravenous (I.V.) heparin was reinstituted on the 13th day. Urine culture on the 13th day yielded *Klebsiella* organisms in greater than 100,000 colonies per ml. This complication was treated with I.V. cephalosporin. Culture from a breast aspiration on the 22nd hospital day revealed no growth. Subcutaneous heparin was substituted for I.V. heparin on the 22nd day, and left simple mastectomy was performed on the 24th day. The patient remained on heparin and oral cephalosporin after surgery. Postoperatively, on the 29th hospital day, superficial thrombophlebitis developed in the right antecubital fossa at the site of an intravenous infusion. The patient did well otherwise and was discharged 42 days after admission.

Examination of the resected breast revealed the skin, nipple, and areola to be necrotic. The entire specimen was marked by hemorrhage and necrosis. Histologic examination showed massive necrosis with diffuse venous

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Submitted April 24, 1973.

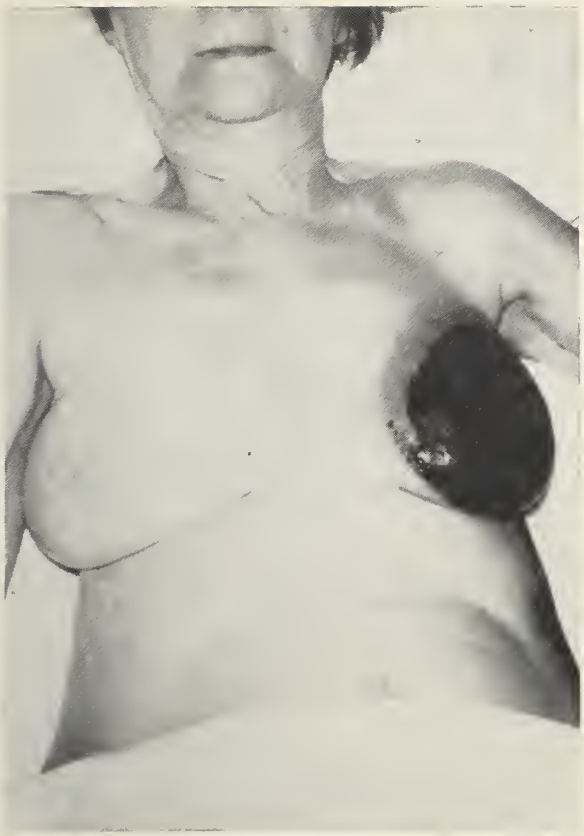


FIG. 1. Gangrenous lesion with surrounding erythematous ring ten days after its initial appearance. Area of involvement included left chest wall as well as most of the breast.



FIG. 2. Higher magnification of Figure 1.

thrombosis and marked arteritis involving the medium and small vessels (Figs. 3 and 4). Also, vasculitis composed of mostly lymphocytes and plasma cells was found at the periphery of the necrotic tissue. It resembled the vasculitis found in rejection reactions (Figs. 5 and 6).

Discussion

Table I is a summary of the documented cases of coumarin-related breast necrosis, which have appeared in the English literature. According to this review, the typical patient with breast necrosis is a middle-aged or elderly woman, who developed thrombophlebitis of the leg for which she was placed on coumarin therapy. Between the third and sixth day after initiation of coumarin therapy, the typical patient suddenly complains of unilateral mammary pain without a history of trauma or infection. On examination, their breasts are swollen and tender and quickly form a dry, blue-black discoloration of the skin with a surrounding erythematous halo. The progression is not halted by discontinuation of therapy or administration of vitamin K. In some patients who demonstrated this complication, the same or related medications were continued without causing involvement of additional areas.

Microscopically, the changes of acute necrotizing arteritis, small vessel thrombosis, and massive fat necrosis seen in our case corresponded to changes previously reported. These histologic characteristics differentiate breast necrosis from other conditions caused by hemorrhage per se.[2-4] Thus, from both a clinical and microscopic standpoint, our case is similar to those described in the prior literature.

The exact mechanism by which the coumarin group of drugs exercises its harmful effect is unknown, but five theories have been advanced. The first suggests the possibility that necrosis is a result of a generalized thrombotic process which occurs despite anticoagulant therapy.[2] The fact that venous thrombi have been found in breast tissue in all reported cases adds credence to this proposal. However, there is no evidence to indicate that the thrombi are caused by a hypercoagulable state rather than vascular inflammation in the absence of hypercoagulability. Also, it is rare for breast necrosis to appear with heparin therapy or in untreated patients.

The second theory proposes that necrosis is secondary to hemorrhage.[2] The high prothrombin times in many of the reported cases support this idea. However, thrombosis and arteritis are not a part of the typical pattern of simple hemorrhage.[2] In addition, it would be likely that hemorrhage

should be found in organs other than the breast, but in no case was this discovered.

The third theory asserts that the necrosis is a result of a hypersensitivity reaction to coumarin congeners.[2] The histologic finding of necrotizing arteritis supports this premise. It is unusual, however, to find the vascular lesions of hypersensitivity limited to localized areas. Also, one would expect additional necrosis to occur if the patient were again given coumarin therapy after an initial sensitizing dose. One such case has occurred,[5] but at least two patients have been continued on or restarted on coumarin after the necrosis developed and no further complications have been found.[2,6]

The fourth theory proposes that coumarin has a toxic effect which acts directly on the vascular system of the skin in the dermovascular loop at the junction of the capillaries and the precapillary arterioles.[7] Again, this hypothesis seems unlikely because continued coumarin therapy usually does not influence the course of the lesion nor does it cause new lesions.

The fifth theory is that the necrosis is secondary to the Shwartzman phenomenon.[8] The Shwartzman phenomenon is the sudden onset within 24 hours of a lesion which rapidly progresses to hemorrhagic necrosis. The lesion is a result of local skin reactivity to bacterial filtrate.[9] Martin and Phillips note striking physical and histologic similarities between coumarin-related tissue necrosis and the cutaneous lesions of purpura fulminans. They cite Quick,[10] who thinks it likely that purpura fulminans is a manifestation of the Shwartzman phenomenon.

Necrosis of the breast unrelated to coumarin therapy has been reported rarely. Isolated cases have been documented in carbon monoxide poisoning, diabetes mellitus, and hemolytic streptococcal gangrene of the breast.[2,11] One case has been reported in which thrombophlebitis of the leg was present, no anticoagulant had been administered, and necrosis of the breast occurred.[12]

Thus, it seems probable that coumarin-related breast necrosis is an immunologic phenomenon. Histologically, the breast tissue in our case had the appearance of vasculitis found in rejection reactions. It is well documented that infectious agents, especially streptococcus and meningococcus, predispose toward hemorrhagic skin necrosis.[10] In contrast to other reported cases which were without infectious processes, our patient had a *Klebsiella* urinary tract infection at the time of the onset of her lesion. Perhaps the combined antigenic stimuli of the infectious process and the toxic effect of coumarin therapy were enough to trigger a



Fig. 3. Large thrombosed vein at edge of necrotic breast tissue.



Fig. 4. Medium-sized artery with arteritis and recent mural thrombus.

rejection reaction which localized in the breast in our patient.

In any event, whatever the pathogenesis may be, the treatment of hemorrhagic breast necrosis has usually been simple mastectomy. At least two cases have been allowed to slough with good results.[6,13] Heparin, corticosteroids, dextran, and antibiotics have been suggested as therapeutic modalities, but no reports concerning their effectiveness are available.

Acknowledgement: We appreciate the technical assistance of Gordon Streicher, and the advice and encouragement of Thomas G. Skillman, M.D., Professor of Medicine, Division of Endocrinology and Metabolism, The Ohio State University College of Medicine.

References

Generic and Trade Names of Drugs

Bishydroxycoumarin — Dicumarol (Abbott)
Sodium heparin — Heparin Sodium (Upjohn)
Sodium warfarin — Coumadin Sodium (Endo), Panwarfin (Abbott)
Sodium cephalosporin — Keflex (Lilly)
Streptokinase — Varidase (Lederle)
Phenindione — Danilone (Schieffelin), Hedulin (Merrill-National)

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Summary of the Documented Cases of Coumarin-Related Breast Necrosis Appearing in the English Literature

Patient	Age	Sex	Admitting Diagnosis	Total Coumarin Dosage	Highest Prothrombin Time	First Day of Necrosis	Treatment	Reference
1	49	F	Thrombophlebitis and pulmonary infarction	Unknown	60 sec	Day 3	Vitamin K and surgery	NY State J Med 43:1121, 1943
2	43	F	Thrombophlebitis	4800 mg dicumacyl	19 sec	Day 3	Vitamin K and surgery	Acta Med Scand 148:450, 1954
3	71	F	Thrombophlebitis	550 mg dicumarol	9%	Day 5	Vitamin K and surgery	Acta Med Scand 154:477, 1956
4	71	F	Pelvic phlebitis	375 mg dicumarol	9%	Day 5	Slough	Acta Med Scand 154:477, 1956
5	65	F	Congestive heart failure, myocardial infarction, and breast ecchymosis from fall	550 mg phenylin-danedion	9%	Day 3	Vitamin K and surgery	N Eng J Med 265:638, 1961
6	46	F	Thrombophlebitis	450 mg bishydroxy-coumarin	36%	Day 4	Vitamin K and surgery	N Eng J Med 265:638, 1961
7	54	F	Thrombophlebitis and pulmonary infarction	400 mg phenindione	22%	Day 3	Surgery	Br J Surg 50:773, 1963
8	72	F	Thrombophlebitis	40 mg dicumarol	46 sec	Day 5	Surgery	Am J Surg 111:728, 1966
9	44	F	Thrombophlebitis	Unknown	37 sec	Day 5	Slough	Am J Surg 111:728, 1966
10	62	F	Thrombophlebitis	Unknown	34 sec	Day 5	Vitamin K and surgery	Am J Surg 111:728, 1966
11	49	F	Thrombophlebitis	Unknown	Unknown	Day 6	Vitamin K and surgery	Am J Clin Path 53:622, 1970
12	75	F	Thrombophlebitis	65 mg coumadin	48 sec	Day 5	Surgery	Am J Clin Path 53:622, 1970
13	63	F	Thrombophlebitis	47 mg sodium warfarin	23 sec	Day 5	Surgery	NY State J Med 71:245, 1971
14	46	F	Thrombophlebitis	100 mg phenindione	30 sec	Day 3	Slough	Br J Surg 58:624, 1971
15	61	F	Thrombophlebitis	52.5 mg coumadin	32.5 sec	Day 4	Surgery	Ann Surg 175:647, 1972
16	73	F	Pulmonary infarction	50 mg coumadin	38 sec	Day 4	Surgery	Ann Surg 175:647, 1972

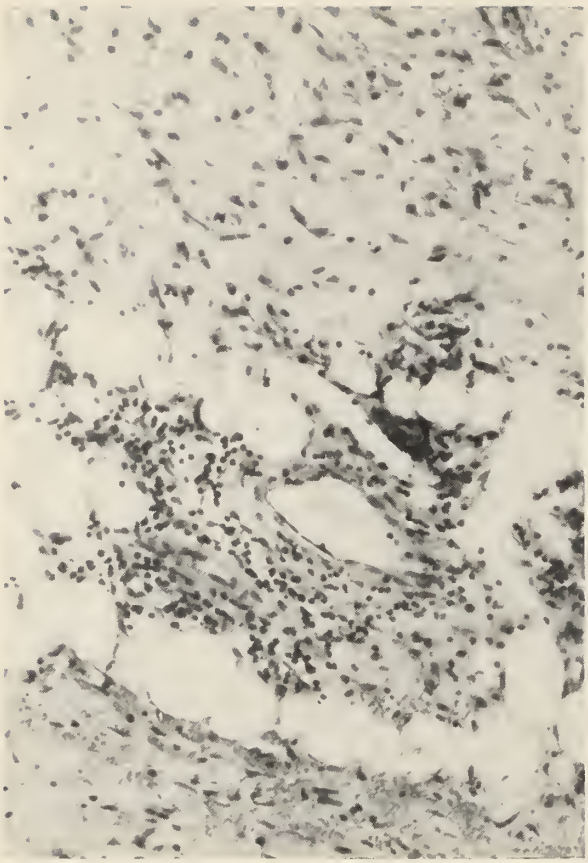


FIG. 5. Vasculitis composed of mostly lymphocytes and plasma cells at periphery of necrotic breast tissue. Resembles vasculitis found in rejection reactions.

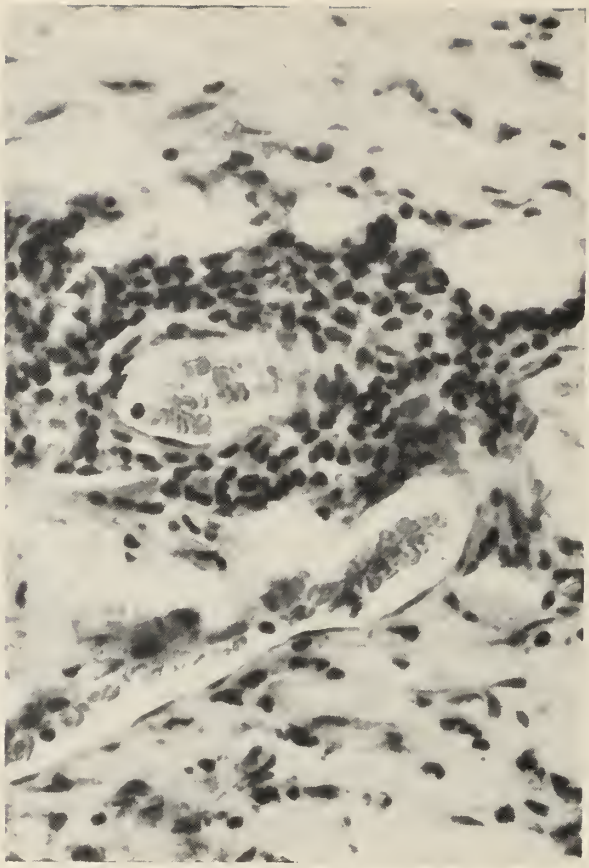


FIG. 6. Higher magnification of Figure 5.

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Community Health News

Ohio Department of Health

John H. Ackerman, M.D., Deputy Director

Gonorrhea Testing

We have recently been provided with an analysis of the "Gonosticon Dri-Dot" test for gonorrhea by the Center for Disease Control.

This test should NOT be used as a screening test of choice in populations of men or women at high risk of infection since it lacks the sensitivity and specificity of culture in both males and females and of the Gram stain in males. There is insufficient data available to assess the usefulness of this test in low-risk populations.

There is great potential danger that use of this test rather than culture will result in many missed diagnoses contributing to further transmission and complications of the disease.

Physicians are reminded that this test is not an acceptable diagnostic test under the recently enacted law requiring prenatal testing for gonorrhea.

Measles (Rubeola) Reporting

Since the advent of an effective vaccine, early reporting followed by intensive immunization programs has been shown to be useful in curtailing the further spread of measles in the community.

In accordance with Resolution No. 108 adopted by the American Medical Association House of Delegates in June 1973, we ask your cooperation in intensifying your efforts to report all cases of measles.

Editor's Note: Resolution No. 108 entitled "More Complete and More Prompt Reporting of Measles (Rubeola)" was introduced by the AMA Section on Preventive Medicine, and the adopted resolved part reads as follows:

"Resolved, That the American Medical Association encourage and request all physicians and others charged with the responsibility for reporting cases of measles to report them **promptly, preferably by telephone,** to the local and state public health officials concerned; and be it further

"Resolved, That both public health officials and those in the private practice of medicine be encouraged to intensify and expand their efforts at immunization of persons susceptible to measles whenever second or successive generation cases of measles are detected in a locality."

Discussion of E.N.T. Case of the Month

(continued from p. 37)

The diagnosis of any persistent oral ulceration should be made by biopsy. This may be done as an office procedure using a topical or injected anesthetic. In this instance, a small wedge taken through the lesion revealed a squamous cell cancer. One word of caution in biopsying lesions that have an ulcerative center; be sure to obtain a section through the margin of the lesion, and not simply the center, which often will reveal only necrosis.

When the diagnosis of a cancer of the tongue is made, the extent of the lesion should be evaluated by palpation. This is an extremely important step, since carcinoma of the tongue frequently infiltrates beneath the intact mucosa and palpation may reveal a much larger tumor than is suspected. In this patient, the small ulcer was the external manifestation of a 4X5-cm submucosal tumor.

Carcinoma of the tongue also may be multicentric in origin and it is extremely important to evaluate the surrounding mucosa. Staining the patient's oral cavity with toluidine blue is helpful, in that small satellite carcinomas not readily visable to the naked eye will stain blue, making them quite obvious.

Because of the size of the tumor, this patient was treated with a hemiglossectomy and right radical neck dissection. He has a good vocal function, normal deglutition, and is alive and well, three years after surgery.



The irritations of man's day are often reflected in his gut.

The causes of irritable colon and the diarrheal symptoms that often accompany it can be as diverse as the systemic and emotional irritations man is faced with daily.

Although the mucoid nature of stools and the occurrence of diarrheal episodes coincident with times of emotional stress may be valuable clues to the functional nature of the disorder, irritable colon must often be diagnosed by exclusion. Such diagnostic exploration takes time. Discovery of the nature of any emotional problems may take more. During that time, Lomotil® is an ideal agent for controlling diarrheal symptoms.

Lomotil tablets are small, easy to carry and easy to take. They act promptly and effectively. Secondary effects are relatively infrequent and, once the first force of the diarrhea is controlled, maintenance is frequently effective on as little as one fourth of the initial dosage.

These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.



Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

takes care of the gut issue in irritable colon

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co., Medical Department
Box 5110, Chicago, Illinois 60680

Professional Activities



Proceedings of The Council

Meeting of November 3-4, 1973

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday, November 3, and Sunday, November 4, 1973, at the OSMA Headquarters' office, 17 S. High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council; Mr. James S. Imboden, Columbus, Assistant Director, AMA Public Affairs Division; Richard L. Fulton, M.D., Columbus, an OSMA Past-President; Mr. George M. Hauswirth, Columbus, representing Mr. James E. Pohlman, OSMA Legal Counsel; Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Houser, Mrs. Wisse, Mr. Moore and Mrs. Dodson, of the OSMA staff.

Those present Sunday were: All members of the Council (with the exception of Thomas W. Morgan, M.D.); Richard L. Meiling, M.D., Columbus, Chairman of the Ohio Delegation to the AMA, and all members of the OSMA staff.

Dr. Schultz Honored

The Council opened its meeting with a presentation of a gift from the Council to William R. Schultz, M.D., honoring him on his designation as a distinguished alumnus of Wooster College. By official action, the Council congratulated Dr. Schultz.

Letter from Mrs. Fishman

The Council received a letter from Mrs. Florence Fishman, acknowledging a contribution of the OSMA to the Bancroft School, in honor of the late David Fishman, M.D., Fifth District Councilor, who died May 22, 1973.

Sympathy Expressed

The Council voted to express sympathy to B. Leslie Huffman, M.D., on the death of Mrs. Huffman, November 3, 1973.

Laura Lockhart Congratulated

By official action, the Council congratulated Laura Lockhart on her election to the vice presidency of the American Association of Medical Assistants.

New OSMA Staff Member

Dr. Clarke introduced Douglas R. Houser, who became a member of the Executive Staff, October 23, 1973.

Minutes Approved

Minutes of the Council Meeting, September 29-30, were approved.

Membership Statistics

Statistics indicated that both Ohio State Medical Association and American Medical Association membership in Ohio exceeded 1972 totals. As of October 29, OSMA membership totaled 10,463 and AMA Ohio membership totaled 8,238. The 1972 year end figures were 10,365 for OSMA and 8,203 for AMA.

American Medical Association

Dr. Meiling reported on plans for Ohio's

AMA Delegation at the 1973 Clinical Session in Anaheim, California, December 1-5.

OSMA Annual Meeting

Mrs. Dodson presented a progress report and plans for the 1974 Annual Meeting, May 12-15. in Cleveland.

Committee Reports

Committee on Insurance

Mr. Campbell presented minutes of the meeting of the Committee on Insurance, October 3, 1973.

OSMA Sponsored Disability Income Insurance

The Council **adopted** the following statement which was recommended by the Committee on Insurance:

"The Ohio State Medical Association is aware of the many local society and academy sponsored disability insurance plans underwritten by the Commercial Insurance Company. The Association desires to add its co-sponsorship to these plans and sponsor the program in those areas where it is not presently sponsored. By so doing, the Association hopes to add additional stability to all local plans; help to provide, through a greater spread of risks, broader coverages; and make available the same plan to all member physicians in Ohio.

"It is not the intent of the Association to interfere, in any way, with the local identification or administration of any presently sponsored plans in this company.

"Turner and Shepard, Inc. of Columbus is hereby named as Agent of Record and Administrator of the Association sponsored plan. In counties accepting the state's co-sponsorship, the administrator would continue to be the same as that agent presently administering such program. The Association's contact would be only with Turner and Shepard, Inc., which would handle any situations involving other agents."

The staff was instructed to obtain updating of information for policy-holders with clarification as to how their situation differs under the new arrangement.

The Council **approved** the committee's recommendation that evidence be collected and documented concerning insurance companies and that this data be applied to the resolve portions of Am. Resolution 38-73 and that the resolution be communicated to the American Association of Medical Society Executives.

The Council **approved** the recommendation of the committee that further work on Am. Resolution 43-73 (Malpractice "Nuisance" Suits) be deferred to await final disposition of a case in California, challenging the constitutionality of such proposals.

The Council voted to inform the Committee on Insurance its recommendation that the OSMA Insurance Committee serve as a research and credential committee on automobile insurance companies did not meet with the approval of the Council.

The report was accepted, as amended.

Committee on Private Practice

Minutes of the meeting of the Committee on Private Practice of October 10, were presented by Dr. Lieber.

The following recommendations of the committee were **approved** by the Council:

"1. A drug alert program be developed to carry to the privately practicing physician at the grass roots, information regarding denial of patients the benefits of important, useful prescription drugs.

"2. Council of the OSMA formally go on record in opposition to this FDA action.

"3. Rosters of members willing to testify in support of effective prescription drugs be prepared.

"4. Composite results of a national questionnaire on effective drugs be widely publicized.

"5. FDA announcements of proposed withdrawal of drugs be published in *The Ohio State Medical Journal* monthly under the heading: "Practicing Physician Drug Alert," on a special page, and that copies be sent to all county medical societies and state specialty societies.

"6. That efforts be redoubled to get more private practitioners on the various FDA review panels."

Also **approved** was the committee's recommendation that the OSMA be on record as being in opposition to an Ohio Society of Hospital Pharmacists resolution regarding anti-substitution laws as being "inconclusive and without substantiation."

Also **approved** was the committee's proposal that any efforts to repeal Ohio's anti-substitution laws be strongly and forcefully opposed by OSMA.

The Council voted to oppose a bill by Senator Gaylord Nelson to outlaw the sale of drugs by brand names.

The report of the committee was accepted, as amended.

Hearings

The forthcoming Kennedy drug hearings were discussed and the staff was directed to prepare a suitable testimony with regard to the Ohio State Medical Association policy and to leave to the decision of President Clarke, the information techniques to be used.

OSMA-OSBA Liaison Committee

Minutes of the meeting of the OSMA Delegation to the OSMA-OSBA Liaison Committee of

October 10, were presented by Dr. Clarke.

The report was accepted.

Committee on Emergency and Disaster Medical Care

The minutes of the meeting of the Committee on Emergency and Disaster Medical Care of October 20, were presented by Mr. Rader.

The Council **approved** the committee's recommendation that OSMA endorse the concept of categorization of hospital emergency departments as a part of total emergency care in Ohio.

Also **approved** was the recommendation that the paper presented by Dr. Waltz on categorization be published in *The Ohio State Medical Journal.*

At the suggestion of the committee, the Council **voted to endorse** the modification of H.B. 168, the school emergency form adopted by the Ohio Legislature, in order that the form will not inhibit action on the part of school authorities in emergency situations.

The Council further **endorsed** the committee's suggestion that the Attorney General be approached for a modification on a short term basis until legislation can be passed.

The report, as a whole, was accepted.

Committee on Environmental and Public Health

Minutes of the meeting of the Committee on Environmental and Public Health of October 31, were presented by Mr. Rader.

The Council **approved, in principle,** the committee's recommendation that OSMA prepare bulletins for plant physicians regarding changes in the Occupational Safety and Health Act and to encourage them to remain up-to-date on occupational health and safety changes.

The Council accepted the concept of bulletins being sent when necessary, but that the committee be made aware of budget problems in the communications area.

A suggestion of the committee with regard to the problems involving peripheral neuropathy was modified to express the opinion that if information is issued with regard to the problem of certain chemicals in industrial plants, it be issued jointly with the Ohio Department of Health.

The Council **approved** a proposal that a notice be sent to the Ohio Hospital Association encouraging its members to see to it that hospital personnel receive adequate immunization against smallpox.

The report was accepted, as amended.

Council Fee Review Committee

Mr. Campbell reported on the meeting of the Council Fee Review Committee of November 2, 1973.

The Report was **approved** by the Council.

AMA Standard Forms for Claims Report

The Council discussed the AMA's announcement that a standard form for claims reporting is now available after two years of study and development by representatives of government, insurance, Blues, and medicine.

The staff was instructed to obtain a supply of the forms and to send samples with a forthcoming issue of the *OSMAgram.*

Workshops for New Physicians

A proposal from AMA-ERF for a practice management workshop for new physicians was discussed by the Council. At the suggestion of Dr. Hogg, the Council voted to permit the Academy of Medicine of Cincinnati to sponsor the seminar and finance it in Ohio, with co-sponsorship from OSMA, provided that it is made available to all senior residents in Ohio.

MAI-Peer Review Systems

Dr. Henry discussed the minutes of the MAI Board of Trustees meeting of October 24, for the information of the Council.

Dr. Gaughan discussed the minutes of the MAI-Peer Review Systems Council meeting of October 28, for the information of the Council.

A contract with MAI-Peer Review Systems for the services of Herbert E. Gillen **was approved.** The Council voted to negotiate a contract on the same terms for the secretarial services of Miss Dorothy Wilgus.

A resolution submitted by the Delaware County Medical Society, concerning Medical Advances Institute was received by the Council.

Other State Meetings

The following reports were presented on other state medical society meetings: Indiana—Dr. Fulton; Michigan—Dr. Morgan; Virginia—Dr. Bates, and Kentucky—Dr. Henry.

Ohio Medical Indemnity, Inc.

Dr. Schultz reported on the October 17, 1973, OMI Board of Directors meeting. He indicated that for the 8 months ending August 31, $5,468,-000.00 was transferred to the general reserve, bringing the total reserve to $29,822,000.00, which is the equivalent of 3.25 months of annual monthly claims and expenses.

Drs. Schultz, Lieber and Wells reported on the Blue Shield Annual Program Conference, held in Chicago, October 25-26.

Ohio State Medical Board

Mr. Page presented to the Council for information the following report from the Ohio State

Medical Board, as transmitted by Mr. William Lee, October 31, 1973:

Re: Licensure Data

Physicians Licensed by Board Action at Regularly Scheduled Board Meetings between 1/73 and 6/73	156
Physicians Licensed by Board Action at Regularly Scheduled Board Meetings from 6/73 when Poll Votes Started to Present Time	184
Physicians Licensed by Poll Vote from 7/73 to Present	222
Physicians Licensed by Endorsement from 1/73 to Present	562
Total Number of Physicians Licensed in Ohio from 1/73 to Present	1467
Total Number of Limited Practitioners Licensed in Ohio from 1/73 to Present	178

Constitution and Bylaws

Amendments to the Amended Articles of Incorporation and Amended Code of Regulations of the Academy of Medicine of Columbus and Franklin County **were approved.**

Amendments to the Constitution and Bylaws of the Tuscarawas County Medical Society **were approved.**

The Committee on Membership and Planning was asked to study a student membership category for the Ohio State Medical Association.

Charter

Reissuance of the Charter for the Fairfield County Medical Society was **approved.**

Office Space

A request from the Woman's Auxiliary to the Ohio State Medical Association for space in the new OSMA building was referred to the Building Committee.

Public Law 92-603, Section 221

The Council then discussed a memorandum dated October 25, 1973, and associated documents received from John W. Cashman, M.D., Ohio Director of Health. Said memo concerned a meeting scheduled November 14, 1973, to provide a hearing on a state plan with the implementation of Section 221, Public Law 92-603 "Limitation on Medical Participation for Capital Expenditures."

The Council **approved** the following letter to the Ohio Director of Health:

The Ohio State Medical Association reluctantly but of necessity must voice a strong protest of efforts to initiate the P.L. 92-603, Section 221, program in Ohio without opportunity of time for appropriate review and input by this Association and its physician members.

It is physically impossible for the Association's officers and committees to review the document, obtain grass-roots input from our component county medical societies, correlate such input and present to you our recommendations within the time period asked of the Association.

This Association is anxious and willing to cooperate in any possible manner with your Department. However, we must have the time



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G. PAULINE WELLS, R.N. Admin. Director
HERBERT A. SIHLER, Jr. President
MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals

necessary to accomplish this in a responsible manner.

As a constructive suggestion, I strongly recommend that all documents to be included in the 92-603 project:

(1) be made available to all medical and health care provider groups,

(2) that these groups be given ample opportunity to confer in depth with their respective memberships,

(3) that each group's recommendations be submitted to you in writing,

(4) that the 92-603 project be rewritten to reflect such input,

(5) that the rewritten document be sent to all provider groups for their information and review, and

(6) after those steps are accomplished, the meeting you have scheduled then be conducted.

Without such opportunity to carry out its responsibilities to the membership and to the component medical societies, the Ohio State Medical Association cannot consider itself an effective party to the 92-603 project.

While we appreciate the November 20 date set for delivery of the program to the HEW Chicago Regional Office, we have no choice but to request this change in scheduling.

This letter has been reviewed and officially approved by The Council of the Ohio State Medical Association."

Ad Hoc Committee on Peer Review Concepts

Dr. Gaughan reported on a meeting of the Ad Hoc Committee on Peer Review Concepts, held November 3, 1973.

Dayton Mental Health Center

In answer to a request from the Ohio Department of Mental Health and Mental Retardation, with regard to assistance in investigating the quality of medical care at Dayton Mental Health Center, the Council voted to furnish a member to evaluate data and to offer the quality review of Medical Advances Institute Peer Review Systems.

ATTEST: Hart F. Page
Executive Director

Provisions in OSMA Bylaws Pertaining to Nomination of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Cleveland, May 12-15.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal,* unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 13.

The part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 3, entitled "Nomination of President-Elect."

"Nominations for the office of President-Elect shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be nominated whose names have been filed with the Executive Director at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect must be filed with the Executive Director of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon the filing of such candidate's name, the Executive Director shall prepare and transmit this information to each member of the House of Delegates. No nomination for President-Elect may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (⅔) of the delegates present at the opening session of such meeting. The Executive Director shall cause to be published in *The Journal* in advance of such meeting of the House of Delegates biographical information on all candidates meeting the requirements of filing and transmittal."

Portrait of Dr. Meiling Is Gift of Faculty to OSU College of Medicine



This portrait by the noted artist David Philip Wilson shows Richard L. Meiling, M.D., in uniform with the rank of Major General in the U.S. Air Force Reserve. He is Vice-President for Medical Affairs of Ohio State University.



Dr. Meiling is shown here addressing the College of Medicine Faculty meeting at which presentation of the portrait was made.

The portrait at the left is now hanging in the halls of the Ohio State University College of Medicine, a tribute to Richard L. Meiling, M.D., in recognition of his many years of outstanding service to the college and to University Hospitals.

The artist, David Philip Wilson, of Worthington and Naples, Florida, is recognized as one of the nation's top portrait painters and has put on canvas many Ohio governor's, U. S. Supreme Court justices, and such high ranking persons as President Lyndon Johnson.

Dr. Meiling is the University's Vice-President for Medical Affairs, a newly created post to which he was named in 1970 after serving nine years as Dean of the College of Medicine and Director of the Hospital. He had previously served as Associate Dean and as Associate Director.

During his association with the University, the College of Medicine faculty has increased more than five fold and he has witnessed unprecedented growth in facilities, student enrollment, scope of curricula, development of allied professional training, and the growth of an outstanding Center for Continuing Medical Education.

Dr. Meiling received his medical degree from the University of Munich, Germany. He is a diplomate of the American Board of Obstetrics and Gynecology and of the American Board of Preventive Medicine (Aviation and Space Medicine). He has had an outstanding military career and during World War II served on active duty with the U.S. Army and the U.S. Army Air Forces. He is shown in the portrait in the Air Force uniform with the two-star rank of Major General—one of the few medical men holding such high rank.

After the war he was asked to serve as Medical Adviser to the National Security Committee under the Hoover Commission and on the Medical Advisory Council of the Department of Defense. In 1949 he accepted appointment in Washington as Assistant to the Secretary of Defense for Health and Medical Affairs and as Director of Medical Services of the Department of Defense.

Dr. Meiling has been active in medical organization work and has served on numerous committees locally, statewide and nationally. He is a Past President of the Ohio State Medical Association and is currently serving as chairman of the Ohio delegation to the American Medical Association.

OSMA Headquarters Offices Going Up



This picture was taken in late November as the roof was being laid on the new building. Work is now progressing toward an early completion date.

OSMA's New Headquarters Building--- Potential for Pride in Ownership

FOR THE FIRST TIME in the organization's history, members of the Ohio State Medical Association may take pride in owning their own Headquarters Building. Now nearing completion, the new structure is located at 600 South High Street, on the southern fringe of the Columbus downtown area. The decision to build was prompted by the spiraling cost of rental space and by growing difficulties in obtaining parking for OSMA committee members and visiting physicians in downtown Columbus.

The House of Delegates at its 1973 session established a new category of membership in anticipation of keeping the building program on a sound financial basis, and minimizing future interest on building costs.

Under the new category of OSMA Active Membership, a limited 500 Active Members may help defray the cost of construction by applying for Life Active Memberships. The Life Active Membership is $1,250, an obvious investment in future elimination of annual dues for most physicians anticipating normal lifetimes of practice. For the physician enjoying the peak of his career, the new Life Active Membership lends an air of distinction.

For the physician who has already paid his 1974 OSMA dues, that amount may be deducted from the Life Active Membership total.

Dues paid to a professional society are fully deductible for tax purposes, but each physician should ask his tax consultant as to how best to report the claimed deduction.

Ground was broken for the start of construction at the time of the 1973 Annual Meeting last May. The entire structure is now under roof which permits continuation of the work through the winter. Occupancy is expected by February or early March 1974. Opening of the OSMA Headquarters building will be one more step in development and beautification of German Village, a large area south of the Columbus downtown area that has undergone considerable restoration in the last decade or so.

The entire exterior of the building—brick walls, windows, gables and roofing effect—will be in keeping with the traditional architecture of German Village, without sacrificing the utilitarian purposes of the structure. Bronzed window frames and decorative wrought iron fence sections will add to the traditional appearance.

The main entrance will be at 600 South High Street. A similar entrance will face east onto the parking lot. Arrangements have been made for additional parking space near the building for the use of persons attending evening meetings. The building has two floors above ground and a full basement.

Offices of the Academy of Medicine of Columbus and Franklin County will share space with offices on the second floor. The Academy will share the board room on the second floor for smaller meetings and the large meeting room in the basement for larger meetings.

Occupancy—Early 1974



This is the architect's sketch of how the new OSMA Eecutive Offices will look upon completion. The Headquarters Building is at 600 South High Street, on the southern fringe of downtown Columbus, close to combined I-70 and I-71 freeway.

Art Show Planned

FOR 1974 OSMA ANNUAL MEETING

Space will be provided at the 1974 Annual Meeting of the Ohio State Medical Association, Monday, May 12th through Wednesday, May 15th for a Physicians' Art Show. The Art Committee of the Academy of Medicine of Cleveland will merge their efforts with those of the Committee on Scientific Work of the Ohio State Medical Association, for the creation of a magnificent Art Show at the annual meeting.

Members of the OSMA, their wives (or husbands), who are interested in exhibiting pieces of art work (they personally have created) or who require information concerning the exhibit, should fill out the application included below *without delay.*

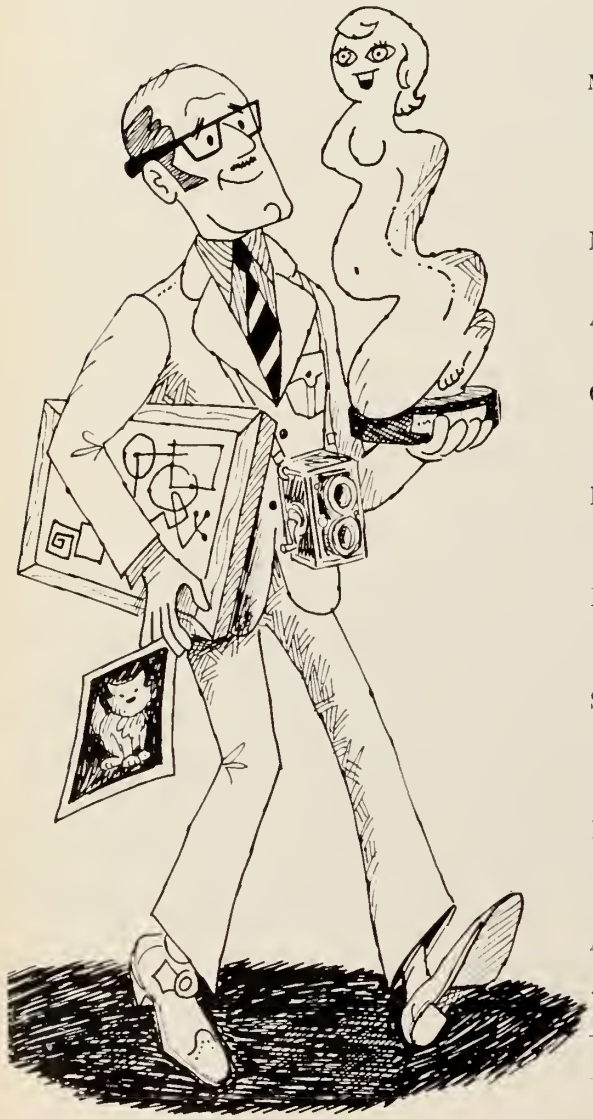
It will be the responsibility of each exhibitor to see that his work gets to the exhibit area, on the balcony of the Exhibit Hall, in the Sheraton-Cleveland Hotel, NO SHIPMENTS WILL BE ACCEPTED. Time to receive such deliveries: Monday, May 13th from 8:00 a.m. to 4:00 p.m. (the earlier the better). No exhibits can be accepted after 4:00 p.m. on Monday, 13th (except by very special arrangements).

Each exhibitor will be responsible for transportation costs, insurance and other expenses involved in entering his or her exhibit. Guards will be provided for protection.

Exhibitors will be limited to two art pieces per category. Categories will be (1) Paintings (watercolor); (2) Paintings (oil) and (acrylics); (3) Sculpture; (4) Photo-Arts; and (5) Crafts.

An independent Art Award Committee will judge the exhibit competitively—ribbons will be awarded.

We solicit your exhibits and hope you will assist us to make the 1974 Art Show an outstanding success.



Application for Space in 1974 OSMA Art Show Exhibit

Mail to: **Victor C. Laughlin, M.D., Chairman**
1974 OSMA Art Show Committee
Academy of Medicine of Cleveland
10525 Carnegie Avenue
Cleveland, Ohio 44106

Name _____

Address _____

City _____ Zip Code _____

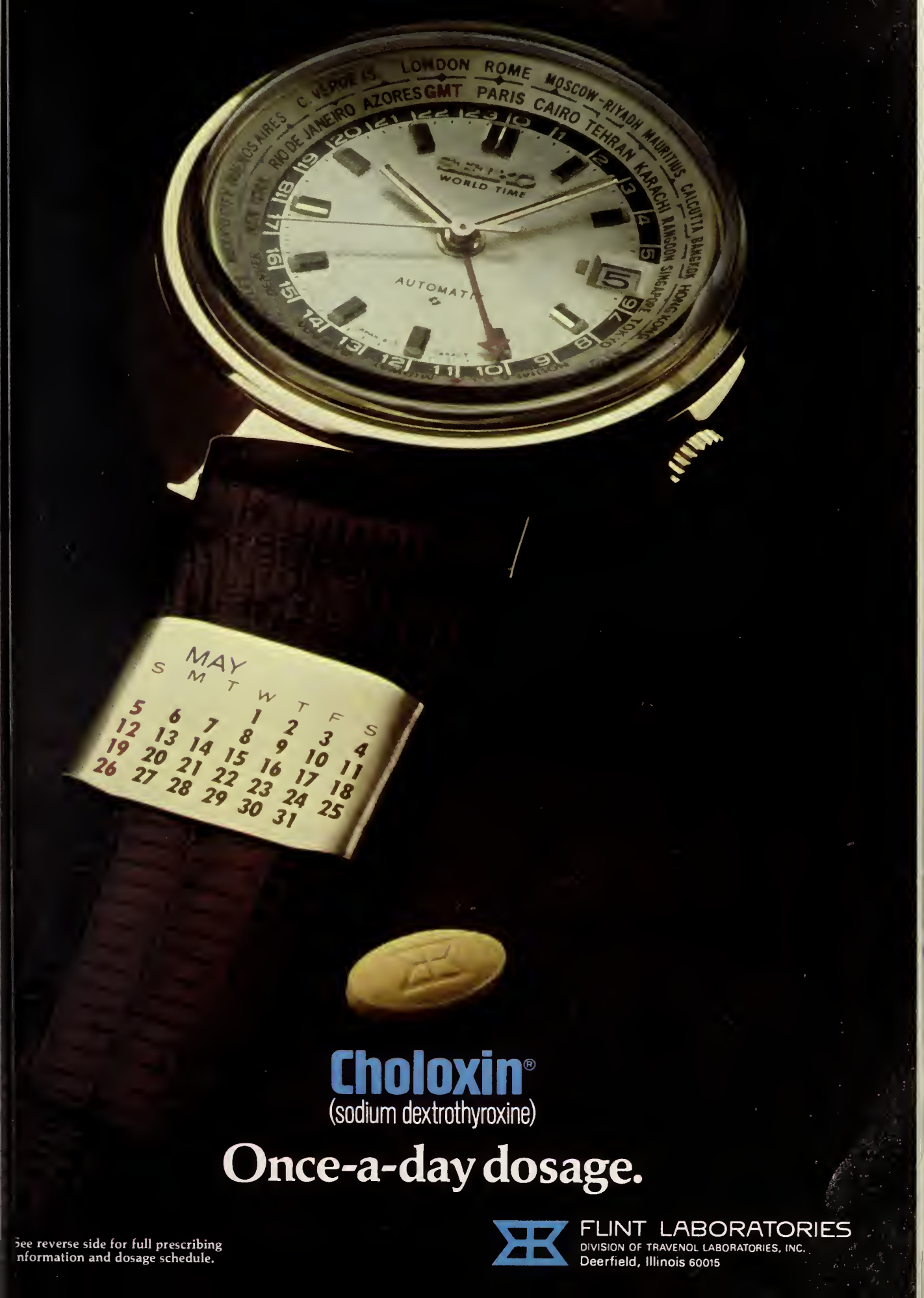
		Title	Dimensions	Va
Paintings (watercolor)	1.			
	2.			
Paintings (oil & acrylics)	1.			
	2.			
Sculpture (pedestal— or wall type—	1.			
	2.			
Photo-Arts (mounted, ready to hang)	1.			
	2.			

Additional information desired or which you believe will be helpful t
Art Show Committee. _____

_____

_____

(*Please include a fair market value for insurance)


LONDON ROME MOSCOW-RIYADH MAURITIUS CALCUTTA BANGKOK HONG KONG TOKYO
PARIS CAIRO TEHRAN KARACHI RANGOON SINGAPORE
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RIO DE JANEIRO AZORES
WORLD TIME
AUTOMATIC
MAY
S M T W T F S
5 6 7 1 2 3 4
12 13 14 8 9 10 11
19 20 21 15 16 17 18
26 27 28 29 30 31 22 23 24 25
Choloxin®
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Once-a-day dosage.
See reverse side for full prescribing information and dosage schedule.
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Four strengths . . . 1, 2, 4, and 6 mg. . . . are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased by Increments of	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	monthly 1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	monthly 0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac Patients	0.5-1.0 mg.	monthly 1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease: history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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New Member Joins OSMA Executive Staff

Dr. Oscar W. Clarke, OSMA President, has announced the appointment of Douglas R. Houser to the executive staff of the Ohio State Medical Association's headquarters office. The appointment was made after conferences between Mr. Houser, the executive staff and officers of the Association.



Douglas Houser

Mr. Houser will work in the field of government relations, being the liaison man between the Association and several governmental offices concerned with medicine and health, such as the Ohio Department of Public Welfare, the Ohio Department of Health, and others. He also will be secretary to a number of OSMA Committees whose interests are in related fields.

The new staff member comes to the OSMA headquarters office from the Ohio Department of Public Welfare where he was administrative specialist in the Division of Medical Assistance. Among his duties there he studied all phases of medical assistance programs, proposing new procedures, and was responsible for establishing the physician billing unit, including the teaching of personnel in computer coding.

Before entering the Welfare office, he was for four years an officer on active duty with the U.S. Air Force in the Medical Service Corps. Among his principal duties during that time he was in charge of administrative support services for the director of the base medical services of a 450-bed hospital which maintained a professional staff of 300 and a paramedical staff numbering more than 500. Administrative duties included those of education and training officer, plant manager, registrar, patient squadron commander, administrative service officer and medical librarian. He is currently a captain in the Air Force Reserve.

Earlier jobs included one with Sears, Roebuck and Company as store display man, and sales jobs with the Lazarus Department Store of Columbus, both during and after completing his college work.

Mr. Houser graduated from Upper Arlington High School in 1960, completed a college preparatory course at the Kentucky Military Institute, Lyndon, Ky., and studied for a year at Ohio State University before going to Otterbein College, Westerville, where in 1965 he received a B.A. degree in business administration. He took additional studies at Ohio State in computer science before going into the Air Force where he received additional training in medical administration.

He is a member of the University Club of Columbus, a member of the Board of Trustees of Zeta Phi Fraternity at Otterbein College and a member of the YMCA Indian Guides.

He and his wife Debbie live at 1882 Stanford Road in Upper Arlington. They have two children Bobby, 7 and Dee Dee, 5.

Mr. Houser is taking over some of the duties formerly performed by Herbert Gillen who is on leave from the OSMA executive staff, working full time for the newly organized Medical Advances Institute.

OSMA Staff Member Accepts Post with MAI

Medical Advances Institute now has its own headquarters office and its chief executive officer is established there. He is Herbert E. Gillen, an executive staff member of ten year's standing with the Ohio State Medical Association, as director of government relations for OSMA. He is on leave from the OSMA post while directing MAI's growing activities.

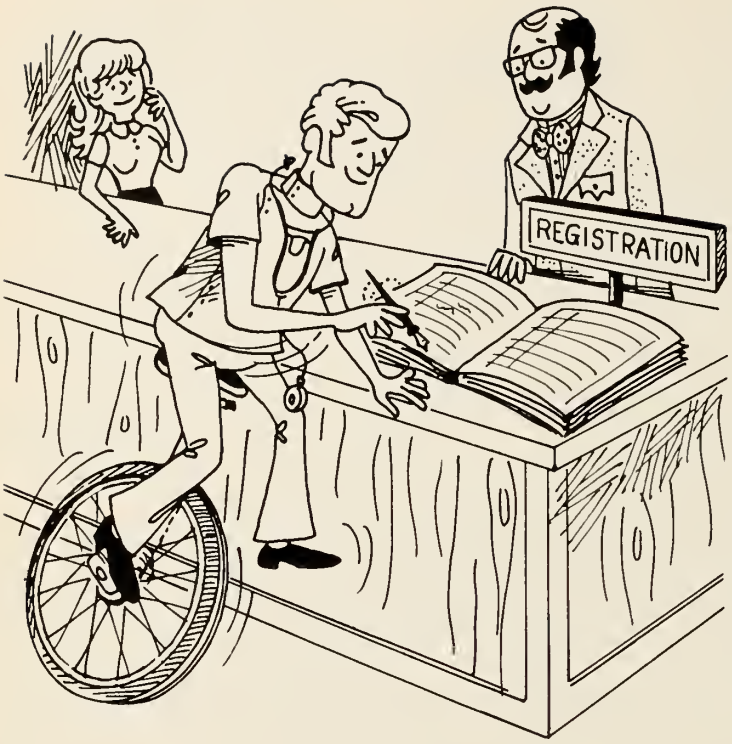
The new headquarters office of MAI is at 1241 Dublin Road, Columbus. MAI is a nonprofit corporation organized by the Ohio State Medical Association operating under direction of a board of trustees made up of physicians and interested nonphysicians.

Mr. Gillen joined the staff of the State Association in 1963, after being associated with the Ohio Department of Health as a health education consultant.

A native of Illinois, Mr. Gillen received a bachelor of science degree in school health education from Southern Illinois University in 1956, and a masters degree in public health education from the University of Michigan in 1961. He served a two-year tour of active duty with the U.S. Army beginning in 1956.

His background of training had been in the health education field, and before joining the staff of the Ohio Department of Health, he was associated with the Illinois Tuberculosis Association and the Decatur-Macon County (Illinois) Tuberculosis Association.

Mr. Gillen is married and he and his wife, Betsy, have three children.



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1974 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1974 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Sheraton-Cleveland Hotel, 24 Public Square, Cleveland, Ohio. Exhibit Days and Times will be as follows: Monday, May 13 — 5:30 P.M. - 8:00 P.M.; Tuesday, May 14 — 9:00 A.M. - 4:30 P.M. and Wednesday, May 15 — 9:00 A.M. - 4:30 P.M.

Mail applications to the attention of J. E. Tetirick, M.D., Chairman, Committee on Scientific Work, Ohio State Medical Association, 17 South High Street, Suite 500 Columbus, Ohio 43215.

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1974 Annual Meeting, Ohio State Medical Association

Sheraton-Cleveland Hotel, Cleveland, May 13, 14 and 15

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Obituaries

Daniel Thavin Feiman, M.D., Claremont, Calif.; University of Illinois College of Medicine, 1933; aged 67; died Oct. 30; former member of OSMA: Fellow, American College of Obstetricians and Gynecologists; practitioner in Canton until 1963 when he moved to California; veteran of World War II.

Howard J. Fleming, M.D., Columbus; OSU College of Medicine, 1960; aged 51; died November 18; member of OSMA and former member of AMA; general practitioner in Columbus and in recent years medical director for the Bureau of Vocational Rehabilitation.

Joseph Armstead Ford, Jr., M.D., Chagrin Falls; Duke University School of Medicine, 1942; aged 56; died Oct. 26; member of OSMA, AMA, and the American Psychiatric Association; private practitioner in the Cleveland area since 1955, specializing in neurology and psychiatry; served with the Army Medical Corps during World War II and after the war served with the U.S. Public Health Service and the Veterans Administration.

John Anthony Gabel, M.D., Pickerington; OSU College of Medicine, 1935; aged 61; died Nov. 12; former member of OSMA; member American Academy of Occupational Medicine; former private practitioner in Columbus, specializing in obstetrics; in recent years attending surgeon for the U.S. Defense Construction Supply Center in Columbus.

Gale Clevenger Guthrie, M.D., Akron; OSU College of Medicine, 1916; aged 81; died Nov. 15; member of OSMA and AMA; general practitioner of long standing in Akron and Cuyahoga Falls before his retirement in 1966; veteran of World War I.

Alvin P. M. Hall, M.D., Columbus; Meharry Medical College School of Medicine, 1936; aged 63; died Nov. 4; member of OSMA and Fellow of the American Psychiatric Association; former member of AMA; diplomate, American Board of Psychiatry and Neurology; private practitioner in Columbus and associated with services under the Ohio Department of Mental Hygiene and Corrections, including the post as psychiatric director for the Juvenile Diagnostic Center in Columbus; served in the Army Medical Corps during World War II.

George Doring Ludwig, M.D., Toledo; University of Pennsylvania School of Medicine, 1946; aged 51; died Nov. 24; formerly associated with the University of Pennsylvania Hospital; in 1970 joined the staff of the Medical College of Ohio at Toledo where he was chairman of the Department of Medicine; served in the U.S. Navy, 1947-1949.

William Woodruff McCormick, M.D., Roswell, New Mexico; OSU College of Medicine, 1962; aged 49; died March 25; member of OSMA and AMA; general practitioner for a number of years in the area east of Columbus with offices at Pataskala.

Nelson David Morris, M.D., Toledo; University of Toronto Faculty of Medicine, 1921; aged

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83; died Nov. 5; member of OSMA and AMA; practitioner of long standing in Toledo, specializing in internal medicine.

James Walton Osborn, M.D., Falls Village, Conn.; Western Reserve University School of Medicine, 1939; aged 64; died Nov. 4; former member of OSMA and AMA; member, American Academy of Occupational Medicine and the Industrial Medical Association; retired in 1969 after serving for a number of years as medical director for the Standard Oil Company in the Cleveland area; veteran of World War II.

Hugo Nicholas Sarchet, M.D., Clearwater, Fla.; University of Louisville School of Medicine, 1915; aged 86; died Nov. 4; member of OSMA and AMA; former practitioner in Sandusky and resident of Florida for a number of years.

Mildred Law Snyder, M.D., Middletown; University of Cincinnati College of Medicine, 1919; aged 87; died Nov. 13; member of OSMA and AMA; general practitioner in the Middletown area for more than 50 years.

Otto Frederick Thuss, M.D., Cincinnati; medical degree from the University of Vienna, 1920; aged 81; died Nov. 14; member of OSMA and AMA; native of Germany and practitioner in Cincinnati since shortly after World War I. Among survivors is a daughter, Ingeborg Thuss-Patterson, M.D., also of Cincinnati.

Harlow Kent VanBuren, M.D., Carey; Eclectic Medical College, Cincinnati, 1929; aged 69; died Nov. 14; member of OSMA, AMA, and American Academy of Family Physicians; practitioner of long standing in the Carey community and formerly in association with his father, the late Dr. Robert C. VanBuren; veteran of World War II. Among survivors is a physician son, Dr. Ronald C. VanBuren, of Columbus.

Henry Paul Worstell, M.D., Long Beach, Calif.; University of Iowa College of Medicine, 1928; aged 74; died Nov. 20; member of OSMA, AMA, and the American Academy of Orthopaedic Surgeons; diplomate, American Board of Orthopaedic Surgery; practitioner of long standing in Columbus, specializing in orthopaedic surgery; Treasurer of the Ohio State Medical Association from 1946 to 1952, and active on a number of OSMA committees; on active duty as Captain with the U.S. Navy during World War II, and later a member of the Naval Reserve.

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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964

Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

WANT TO MAKE a "super" New Year's resolution? Join AMPAC-OMPAC! Those of us who attended the "Key Man Conference" in Columbus on Sunday, November 18, came away inspired and with a strong sense of urgency to swell the AMPAC-OMPAC ranks. So what better resolution can old members make than to renew, and what wiser resolution can all other doctors and their wives make than to join?

The membership contributions to AMPAC-OMPAC are used for candidate support — the PAC was organized to meet medicine's need for identification in the elective process — to help elect people of caliber who recognize, appreciate and support the cause of medicine. It is strictly nonpartisan.

Here are some provocative quotes from a leaflet recently published by the American Medical Political Action Committee:

"Politics is not something to avoid or abolish or destroy. It is a condition, like the atmosphere we breathe. It is something to live, to influence if we wish, and to control if we can. We must master its ways or we shall be mastered by those who do."

In 1961, AMPAC was created by the American Medical Association to meet the need of providing the medical profession with an opportunity to assume a more active and effective role in electing candidates to public office. AMPAC is a national, voluntary, nonprofit, unincorporated group whose membership consists of physicians, their wives and members of allied medical professions. State political action committees are separate, autonomous units which function independently of, but in cooperation with AMPAC. AMPAC has two primary objectives. First, it seeks to educate its membership in the political process. Second, it hopes to involve that membership in effective political action.

AMPAC-OMPAC is an important part of medicine in Ohio. The "Key Man Conference" held in November was to further educate and enlist the active help of "key" doctors and their wives over the state. Believe me, this is an important step. I was amazed to find, upon attempting a private poll of my own, how surprisingly uninformed many auxiliary members (and their husbands) are on the matter of AMPAC-OMPAC.

OMPAC scored well in the 1972 election. It had an overall 70 percent winning score — 92 percent in the U. S. Congressional races; 75 percent in the State Senate contests; 66 percent in the Ohio House battles.

Now it is 1974 — a crucial election year. Now is the time for physicians and their wives to make their contribution of $25. Now is the time to gear up. Pooling of the interest, activity and money of many, many individual physicians and their wives through OMPAC is what gives a real wallop to the medical profession's interest in good government and makes the profession a potent factor in political action. OMPAC does not engage in lobbying in the Congress or Ohio General Assembly. It does not formulate policies on medical and other issues. These are the responsibilities of the Ohio State Medical Association, its component county medical societies and the American Medical Association. Obviously, OMPAC keeps itself informed of the policies developed.

"The county level is where the action is," says James S. Imboden, AMPAC Field Staff member

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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Salem, 44460

President-Elect
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Springfield, 45503

Past President
Mrs. Louis Loria
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Bristolville, 44402

First Vice-President
Mrs. Howard E. Smith
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Toledo, 43606

Second Vice-President
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whose headquarters are in Columbus. He points out that it is vitally important to provide information to the county medical societies. And he offers this help: He is available for talks before county medical groups; excellent slides are available that "tell the AMPAC-OMPAC story"; there is an informative news bulletin; and other speakers can be provided at any time. "As OMPAC grows," comments Mr. Imboden, "the voice of medicine becomes stronger."

I couldn't imagine a better lead story for this month's column than that on OMPAC. It's the beginning of a New Year — let it be the beginning of an avalanche of memberships in OMPAC. Resolve to send that $25 in *today*.

Those Fall Conferences

It was an interesting and worthwhile experiment — holding this past year's Fall workshops at four different locations — Findlay, Youngstown, Dayton and Cambridge. The attendance was good and there was outstanding interest and participation. Board members taking an active part in the workshops began to feel like a closely knit (if tired!) family. We certainly got to know each other better and appreciate each other more! A "tip o' the hat" to Mrs. Karl Ulicny, state president; to Mrs. S. J. Glueck, state president-elect in charge of the conferences; and to all the others who worked hard to make it the success it was.

Lucky Ohio! We "bagged" no less a personage to two of the four workshops than National Regional Vice-President, Mrs. Wendell F. Roller of Illinois. In addressing the group at a special session, Mrs. Roller said:

"You came to the workshops and you came for different reasons. It is important that you made the choice to come. You are contributing to the activities of the day and as you relate to each other, you are together searching for what is most important for you to do. . . . We can do much as individuals and as Auxiliary groups. It is important that we work as a team. . . .

"As a member, in what direction do you want this organization to go? Our program is the vehicle through which we can contribute to the quality of life for ourselves and others. We can dream big dreams, decide our role, set our goal and plan our action. The future is where you will spend the rest of your life, so we must look at the major problems of our society as we design our programs."

Mrs. Roller went on to discuss current crises, problems in the schools, equality versus equity, disrespect toward authorities, changing values, changing patterns of survival behavior and the altering of the environment. "We will have to examine our priorities," she said. "Let us remember that without vision, the people perish. Together we can meet the conditions that exist and solve problems with creative reforms. With vision we can help bring health to the people. You, the auxiliary member, hold the key to the future." Mrs. Roller closed her remarks with a "pat on the back": "We commend the Ohio Auxiliary for the excellent work being done and the enthusiasm with which you do it."

Woman In The News

Mrs. William A. Myers, **Pickaway County**, auxiliary state treasurer, was appointed by Governor Gilligan some months ago to the Task Force on Health Care. It is the purpose of this Task Force to study the entire scope of health care in Ohio and to recommend whatever changes, programs or new directions might be necessary for improvement. It is the group's hope that the special report will be ready for the Governor to develop legislative proposals for the second session of the 110th General Assembly beginning this month.

Here and There

Franklin County can boast of 17 new members so far this Auxiliary year. In a recent newsletter, this excellent suggestion was made (and I suggest other counties copy the idea!): "As you current members look over the list of new members given here, notice someone who lives in your neighborhood, call her and invite her to go with you to the next meeting. Remember how lonely you felt at meetings until you got to know some of us!!"

Sally Lewis and her membership committee are credited with doing a terrific job. Congratulations —

Franklin County's mental health committee has been working hard to get items for bingo prizes, making a pitch for cosmetic samples, jewelry, panty hose and other personal items. An SOS also went out from this committee for needed items of clothing for the patients at the State Hospital, such as sweaters, slippers, stockings, etc. Says the committee: "Larger sizes are most needed and **serviceability** is more important than style!"

The Columbus gals can also boast a fine Glee Club — a crafts group, gourmet group and bridge group. All this in addition to their outstanding auxiliary projects. . . .

M.A.S.H.

That's what **Jefferson County**'s annual fund raising dance held at the Fort Steuben Hotel was dubbed. Music for dancing was provided by the Joe Negri Orchestra and refreshments were served —the proceeds going for the group's Medical Ca-

reer's program. This auxiliary year, Jefferson is supporting three new students — two who are part-time at a cost of $750 each, and one full-time at a cost of $1500.

In late September there was a luncheon at the home of Mrs. James V. Current, Jefferson's president. (sorry to be late in reporting this, but sometimes county items coming my way get "waylaid" en route!) Three new members have been welcomed to the group: Mrs. Nissim Benado, Mrs. Gus Fojas and Mrs. Rolly Mupas.

Stark County Activities

Another of those busy groups! Back in October, there was a luncheon at the Canton Woman's Club at which Mrs. Barbara Schreiber of the Canton Board of Education discussed "Education in the Seventies." The November meeting was a luncheon and fashion show at the Congress Lake Country Club.

December 4 was Stark County's day to help at the TB Center during its Christmas Seal Drive. Some members spent the whole day there, others gave a number of hours. Auxiliary members helped the Salvation Army interview applicants for Community Christmas. That, of course, was also in December as was a Holiday Brunch at Holiday Inn at which the program was presented by Judge Ira Turpin. Auxilians brought unwrapped gifts to the brunch that were to be given to boys and girls at the Salvation Army's Community Christmas.

The International Health Committee had a "drug packing" date at Molly Stark Hospital. The Stark auxiliary has participated in collecting drug samples and equipment for the last ten years! (auxiliaries, nationwide, have contributed some $14 million worth of drug samples!) A recent newsletter suggested that members donate white or pastel shirts with long sleeves to be made into "johnny coats." When the international health committee sorts and repacks drugs, specific ones are kept in the local area to be used by city and county clinics. And there was plenty of activity during November and December selling those special watches, stationery, recipe cards and Christmas cards.

Down Scioto Way

It's been a busy time in this area too for the selling of watches and Christmas cards and no two gals have been busier on that than Mrs. B. U. Howland and Mrs. John Walker. The Scioto auxiliary's November meeting was at the home of Mr. and Mrs. Armin Melior. The business session was conducted by Mrs. Ralph Lewis, president. A moving tribute was presented by Mrs. Charles W. Wendelken in memory of Mrs. William Singleton who died in October. (Mrs. Singleton had served on the state board for four years).

The afternoon's program focused on "You're Beautiful," conducted by Mrs. Marie Paul of American Hostess Creations and Merle Norman Cosmetics. The "models" were two auxiliary members — Mrs. George Johnson and Mrs. Jerome Sheets.

"Ring In The New"

Several times I have stood in New York's Times Square on New Year's Eve and waited for the hands of the clock to touch midnight. How many thoustands of men, women and even children stood jammed in with me, I have no way of knowing. But what I remember most is that incredible, marvelous moment at the stroke of midnight.

As the clocks and bells and horns and shouts ushered in the New Year, there was a wonderful sense of friendship that suddenly appeared in this crowd of strangers — there was laughter and warmth and embraces — and for that brief span of time, there was love and hand reached for hand.

If only the world could grasp and hold on to moments like these — and never let them go!

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Table of Contents

Professional Activities and Other Features

(Continued From Page 2)

Page

13 MDs in the News

14 Keeping Up: Continuing Education Opportunities for Physicians in Ohio

18 Hemodialysis Center Slated for Cincinnati VA Hospital

20 "But My Few Dollars Won't Make Any Difference"—An Appeal for the Ohio Medical Political Action Committee

43 Community Health News from the Ohio Department of Health: Gonorrhea Testing; Measles Reporting

50 Provisions Pertaining to Nonination of OSMA President-Elect

54 Art Exhibit Will Be Feature of 1974 OSMA Annual Meeting

57 New Member Joins Executive Staff of OSMA

57 OSMA Staff Member Accepts Post with Medical Advances Institute

58 Make Your Hotel Reservations Now for 1974 OSMA Annual Meeting in Cleveland

60 Obituaries

62 Woman's Auxiliary Highlights

66 The Journal's Advertisers in This Issue

67 Classified Advertisements

JOURNAL ADVERTISERS

Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products and let them know that you see their advertising in *The Journal*.

In This Issue:

Abbott Laboratories 17

The Brown Pharmaceutical Co., Inc. ...8, 19, 61

Burroughs Wellcome Co. 21

Dorsey Laboratories, Div. of Sandoz-Wander, Inc. 12

Flint Laboratories, Div. of Travenol Lab., Inc. 10-11, 55-56

Lilly, Eli and Company 26

McNeil Laboratories, Inc. 3

Mead Johnson Laboratories 15

The Medical Protective Co. 19

Ohio Medical Indemnity 63

Pharmaceutical Manufacturers Association ..24-25

Roche Laboratories, Div. of Hoffman-LaRoche, Inc. ....Inside Front Cover-1, 22-23, Inside Back Cover, and Back Cover

Searle Laboratories, Division of G.D. Searle & Co. 44-45

Upjohn Company 6-7

Video Record, Inc. 65

Warner-Chilcott 9

Wendt-Bristol Company 18

Windsor Hospital 49

Wolman Insurance Agency, Inc. 60

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Box (insert number), c/o The Ohio State Medical Journal
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

PHYSICIAN'S OFFICE FOR RENT in Mariemont, a Village adjacent to Cincinnati, near a good hospital. Contact L. Hermanies, 3900 Oak St., Mariemont, Ohio. Phone 271-0291.

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OHIO MED. LIC. Prerequisite to qualify for full or part-time STAFF PSYCHIATRIST interested in community psychiatry. Flexible 40 hr. wk., including lunch hours, does not require night calls. 1 mo. pd. vacation, paid sick leave cumulative to 120 days total. Opportunities to attend selected lectures and seminars on clinic time & expense. Limited private practice. Salary to $33,000, depending upon qualifications. Contact: Dr. Thomas Di Mauro, Dir., Stark County Community Mental Health Center, 618 Second St., N.W., Canton, Ohio 44703 or call collect 216/455-9407.

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PHYSICIAN WANTED

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Notice of Change in Rates for Classified Advertisements

Because of increasing production costs, The Journal's Publication Committee has found it necessary to increase the rates for classified advertisements. The regular charge for classified advertisements beginning January 1, 1974 is $1.00 per line as set in type.

The rate for Display Classified Advertisements (ads other than those set in regular light face type, or boxed ads) is $2.00 per line.

All classified ads placed with The Journal office before this announcement was published will be carried at the old rate until completion of the commitment period.

FOR RENT OR LEASE - General Practitioners Office for 10 years. Suite of 4 rooms—central airconditioned—carpeted—paneled. Parking in rear. Phone: 614/224-6972 or 614/231-1987.

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— More Classified Ads on Next Page —

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(Continued from Previous Page)

EMERGENCY ROOM PHYSICIAN. Present group successfully covering two accredited hospitals; $35,000 annual guaranteed salary, plus malpractice and health insurance; Ohio license required; fluency in English. Could be opportunity for physician completing residency in specialty to become known in community prior to establishing private practice. Hospitals will assist with relocation. Contact L. E. Thompson, Administrator, Scioto Memorial Hospital, 1805 27th Street, Portsmouth, Ohio 45662, phone 614/354-1805.

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WANTED: Family practitioners, pediatricians, internists, and obstetricians for dynamic municipal Midwest Health Department providing innovative primary care. Faculty appointment available. Salary $27,500-$30,000 negotiable. Must be eligible for Ohio license. Reply P.O. Box 238, Cincinnati, Ohio 45202.

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Editor's Note: The Journal presents the following classified advertisement to its readers as an announcement of the physician assistant and assumes no responsibility for the statements made.

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EMERGENCY ROOM PHYSICIAN — Modern, 350-plus bed general hospital located in pleasant midwestern city of 45,000 pop. seeks E.R. Physician to cover expanding service. Will join staff of four experienced E.R. Physicians in new facility. Salary range: $35-000-$40,000. Please send resume to Box 698, c/o Ohio State Medical Journal.

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Contraindications: Patients with known sensitivity to the drug.
Warnings: Caution patients about ole combined effects with alcohol and CNS depressants. As with all cting drugs, caution patients st hazardous occupations requiring lete mental alertness (*e.g.*, oper- machinery, driving). Though physi- d psychological dependence have been reported on recommended , use caution in administering to tion-prone individuals or those who increase dosage; withdrawal symp- (including convulsions), following ntinuation of the drug and similar se seen with barbiturates, have been ted. Use of any drug in pregnancy, ion, or in women of childbearing equires that its potential benefits ighed against its possible hazards.
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dverse Reactions: Drowsiness, and confusion may occur, espe-



cially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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OSMA ANNUAL MEETING

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Cycles of Life & Health

See Pages, 126, 128, 129, 131
Table of Contents, Page 70

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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FEB 22 1974

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Ohio State MEDICAL JOURNAL

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The Ohio State Medical Journal
17 South High Street, Suite 500
Columbus, Ohio 43215

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

Subscription, $5.00 per year to nonmembers; single copy, 50 cents (outside Continental U.S., $6.50 and 65 cents).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertiser must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

Table of Contents

Page Clinical and Scientific Features

95 **Problems and Prospects for Physician Assistants in Ohio. Experience with the Education of Physician Assistants in Anesthesia in Cleveland.** J. S. Gravenstein, M.D., et al, Cleveland.

98 **The Community and the Institution.** Gerhard E. Martin, M.D., Columbus.

101 **E.N.T. Case of the Month.** Andrew W. Miglets, Jr., M.D., Columbus.

102 **Medical Education: Medical Education Workshops. A Study of Their Influence on Teaching Behavior of Medical College Faculty.** William C. Farr, M.D., Tucson, Ariz., and Mary Heider, Ph.D., Cincinnati.

106 **Hydrothorax Complicating Subclavian Vein Infusion Therapy. A Case Report.** Stewart P. Chase, M.D., Columbus.

108 **Abortion and Red Rubber Catheters. A Case Report and Discussion.** Amrutha Bhakthavathsalan, M.D., and Melvern A. Ayres, M.D., Toledo.

111 **Nephrology Page: When the Serum Sodium Is Low.** Leonard B. Berman, M.D., Cleveland.

Special Article

72 Improving Emergency Medical Service in Ohio By Robert C. Waltz, M.D., Cleveland

Professional Activities

117 Report on AMA Clinical Convention in Anaheim

121 Matters Considered and Actions Taken at December 15-16 Meeting of The OSMA Council

126 Plans Show High Points of 1974 OSMA Annual Meeting

Letter of Protest Regarding Proposed Readmission Review of Medicare and Medicaid Patients—Insert following page 132

(Continued on Page 138)

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Improving Emergency Medical Service in Ohio

Robert C. Waltz, M.D.
Cleveland, Ohio

DURING THE PAST FIVE YEARS a concept of Emergency Care has evolved that requires the assessment of each hospitals total institutional capability for providing emergency service. This was outlined in some detail in a booklet by the National Academy of Sciences in 1966 entitled *Accidental Death & Disability: The Neglected Disease of Modern Society*. These suggestions have been acclaimed by the American Medical Association, and the American College of Surgeons both of which have played a long and active role in the area of Emergency Care.

In a recent report of the Committee on Emergency Medical Services of the National Research Council titled "Roles and Resources of Federal Agencies in Support of Comprehensive Emergency Medical Services," the gravity of the problem of Emergency Health Care was illustrated by the following facts.

> "Accidental injury and acute illness generate a staggering demand on ambulance and rescue services, allied health personnel, physicians, and hospitals, for the delivery of emergency medical services. Accidental injury is the leading cause of death among all persons aged 1 to 38. Each year more than 52 million U.S. citizens are injured, of whom more than 110,000 die, 11 million require bed care for a day or more, and 400,000 suffer lasting disability at a cost of nearly $3 billion in medical fees and hospital expenses, and over $7 billion in lost wages. Those requiring hospitalization occupy an average of 65,000 beds for 22 million bed-days under the care of 38,000 hospital personnel. This hospital load is equivalent to 130 500-bed hospitals. Of the more than 700,000 deaths from heart disease each year, the majority are due to acute myocardial infarction and more than half of these deaths occur before reaching a hospital. Approximately 40 million persons seek care each year in hospital emergency departments as a result of accidents, heart disease, stroke, poisoning, diabetic coma, convulsive disorders, and many other illnesses."

Through the media of the press and television programs such as "Emergency" and "Police Surgeon," the public also has become aware of the need for improved emergency services. The public is also becoming alarmed and angered by the archaic methods used to transport patients to some of the nation's most sophisticated medical centers, and an aroused public frequently sets the stage for corrective legislation.

Congressional interest in emergency medical service has been high. President Nixon vetoed the Emergency Medical Services Systems Act of 1973 as being "far in excess of the amounts that can be prudently spent." He was also critical of the amendment for keeping eight Public Health Service hospitals open. Immediately after the House failed to override the veto (the Senate overrode 77 to 16, but the House failed by only four votes) measures were introduced in both House and Senate that duplicated the vetoed bill except for the controversial PHS amendment. Substitute legislation has been signed by the President. The new law is P. L. 93-154.

This bill provides for creation of a comprehensive emergency medical service system throughout the country. While direction and financial assistance would be provided at the federal level, the program is focused at the level of the individual community, and is designed to help communities help themselves.

The Director would collect funds for the State which would in turn distribute funds to communities for development and operation of community emergency medical service programs.

To qualify for an allotment, the State must submit to the Director a plan for improvement of emergency services throughout the State. It will

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Dr. Waltz is Assistant Clinical Professor of Surgery, Case Western Reserve University, and Chairman of the Ohio Committee on Trauma, American College of Surgeons.

Presented in cooperation with a subcommittee on categorization appointed by the OSMA Committee on Emergency and Disaster Medical Care. Members of the subcommittee are Howard S. Madigan, M.D., Toledo; Sterling W. Obenour, M.D., Zanesville; Byers W. Shaw, M.D., Washington C. H.; Dwight S. Spreng, M.D., Cleveland; and Mr. Thomas J. Oberliesen, Columbus, Vice-President for Planning, Ohio Hospital Association.

CHECK LIST 1

EMERGENCY DEPARTMENT SURVEY AND CATEGORIZATION

Hospital Cleveland Metro. General No. Beds 500 No. Emerg. visits 70,000 per year

University ____ University Affiliate X Community ____ Private ____

Administrator William H. Andrews Chief of Staff Walter J. Pories, M.D.

Director of Emergency Department Richard B. Fratianne, M.D. Full time? Yes

Training Programs (To Board Requirements)

Int. Med. X Surgery X Anesth. X Chest X Neuro. X Ped's X OB X

EMERGENCY DEPARTMENT STAFFING AND SERVICE

		24 hrs.	On Call	No
Nursing Service (RN)		X		
Physician (Resident)	Other	X		
Anesthesiologist (Resident)	Other	X		
Blood Bank Staff		X		
Laboratory Technician		X		
X-ray Technician		X		
Radiologist (Resident)	Other	X		
Angiography		X		
Pulmonary function (with blood gases)		X		
O.R. Staffed & available		X		
Major Neurosurgical & Cardiothoracic capability readily available		X		

	Yes	No		Yes	No
Intensive Care Unit (24Hrs.)	X		Coronary Care Unit (24Hrs.)	X	
Pediatric I.C.U. (24Hrs.)	X		Cardiac Catheterization Lab	X	
Recovery Room (24Hrs.)	X		Renal Dialysis	X	
Psychiatric Unit	X		Cardiopulmonary By-pass	X	
Helicopter Landing Site	X		Obstetrics	X	

CATEGORIZATION SUGGESTED BY YOUR MEDICAL STAFF AND ADMINISTRATION:

Category 1	Major Emergency Care	X
Category 2	a. General Emergency Care Hospital	
	b. General Emergency Care Hospital	
Category 3	Basic Emergency Care Facility	
Category 4	Resuscitation & Referral Facility	

Date 11-19-72 Signed William H. Andrews Title Vice-President

11-20-72 R. Fratianne MD Director Emergency Services

therefore be necessary for individual communities, or groups of communities, to establish Emergency Medical Service Councils which will draw up and submit plans for a "qualified emergency medical service system" to the State Coordinator in order to qualify for funding. Emphasis will be on regionalization, integration and mutual compatibility, in order to avoid development of a hodgepodge of individual incompatible "systems."

A "qualified emergency medical service system" will operate within prescribed standards and will include the following basic requirements.

1. Well equipped emergency vehicles staffed by emergency medical service technicians trained and equipped to provide all necessary life support at the scene and during transportation;
2. A communications system that answers prompt response to the need;
3. High quality emergency care facilities, staff, and equipment at the hospital level;
4. Categorization of hospital emergency capabilities within regional planning;
5. Registration of ambulance attendants through a National Registry program;
6. Periodic evaluation by the State.

Although there are other bills on Emergency Service before the House, all contain these same basic requirements, including that of categorization of hospital facilities. Several large cities in Ohio including Cleveland have already categorized their hospitals in preparation for, or in conjunction with a regional "system." This has been accomplished through the combined efforts of their local EMS Council, Medical Society and Hospital Association.

In Cleveland categorization was accomplished voluntarily by the hospital Chief of Staff and Administrator using guidelines established by the Academy of Medicine of Cleveland. Each hospital was sent background information relating to the need, and principles of, categorization, outlines of specific categories, and a check list. At the bottom of the check list each hospital Chief of Staff or Administrator was to indicate the category he believed his hospital should be placed. (See Check Lists 1 and 2.) Thirty-one hospitals were contacted with response from all but one. The committee found it necessary to change only one of 30 self-categorizations.

Categorizing does not imply that one hospital is "better than" another, or that all patients with severe injuries or heart attacks should be transferred to an "Ivory Tower." Physicians and small hospitals having the capability of managing such problems should be encouraged, with State and local EMS Council helping improve ancillary and hospital emergency support services. It should be apparent, however, that duplicating expensive support systems is unsound. Ideally two small hospitals in the same general area should work together towards development of an improved system. If there is antagonism or resentment to the concept of one hospital designated to receive emergency patients, it may be possible to divide responsibility along the lines of one developing a Coronary Care Unit and the other upgrading its Trauma facilities.

Using the American Medical Association guidelines with modification four basic categories are presented.

Category 1, Major Emergency Care Center is basically a University or Teaching and Research Center with complete training programs to board requirements in all specialties. Such centers will have special units such as Pediatric, Intensive Care, Burn Unit, and Head and Spinal Cord Injury Units. This does not mean that **all** burns or head injuries should go to Category I hospitals—only that particularly severe problems **may** be referred to them at the request of other hospitals or physicians. Serious injuries occurring in rural areas evacuated by helicopter may be directed to Category I hospitals which should be equipped with a proper landing site.

Category 2, The General Emergency Care Hospital has received special attention because of the recent closing of many Obstetrical Divisions in otherwise well equipped and staffed hospitals, and are listed as 2A, and 2B (no obstetrics). Such hospitals should have the capability to provide for most but not all emergency patients. Included should be most large community hospitals. Members of the medical staff representing all specialty categories should be available within a short time. It should have such special capabilities as pulmonary function with blood gases, angiography and isotope scanning. The Emergency Department should be staffed by an experienced "in house" physician 24 hours a day. Intensive and Coronary Care Units must also be available and staffed on a 24-hour basis.

Category 3, Basic Emergency Care Hospital. This hospital should have essentially the same capabilities for resuscitation and short term maintenance of life support as **Category 2.** It should have the capability to provide definitive care of many emergencies and provide resuscitation and transfer of others. Hospitals with small staffs or rural hospitals should fit into their group.

Category 4, Resuscitation and Referral Facility. This facility may be hospital or nonhospital based, but is equipped for resuscitation in most life threatening problems. It depends heavily on the availability of well trained allied health personnel who can identify life threatening problems, communicate rapidly with a physician, initiate life

EMERGENCY DEPARTMENT SURVEY AND CATEGORIZATION

Hospital POLYCLINIC HOSPITAL No. Beds 125 No. Emerg. visits 255/mo.

University ____ University Affiliate ____ Community ____ Private X

Administrator Roger W. Marquand Chief of Staff Julius Wolkin, M.D.

Director of Emergency Department None. Medically a responsibility of Director of Surgery Full time ?

Training Programs (To Board Requirements)

Int. Med. ____ Surgery ____ Anesth. ____ Chest ____ Neuro. ____ Ped's ____ OB ____

EMERGENCY DEPARTMENT STAFFING AND SERVICE

		24 hrs.	On Call	No
Nursing Service (RN)		8 hrs.	16 hrs.	
Physician (Resident) Attending	Other		24 hrs.	
Anesthesiologist ~~(Resident)~~	Other		24 hrs.	
Blood Bank Staff		8 hrs.	16 hrs.	
Laboratory Technician		13 hrs.	11 hrs.	
X-ray Technician		9 hrs.	15 hrs.	
Radiologist ~~(Resident)~~	Other	6 hrs.	18 hrs.	
Angiography			24 hrs.	
Pulmonary function (with blood gases)				X
O.R. Staffed & available		8 hrs.	16 hrs.	
Major Neurosurgical & Cardiothoracic capability readily available			24 hrs.	

	Yes	No		Yes	No
Intensive Care Unit (24Hrs.)		X	Coronary Care Unit (24Hrs.)		X
Pediatric I.C.U. (24Hrs.)		X	Cardiac Catheterization Lab		X
Recovery Room 8 to (24Hrs.)	X		Renal Dialysis		X
Psychiatric Unit		X	Cardiopulmonary By-pass		X
Helicopter Landing Site		X	Obstetrics		X

CATEGORIZATION SUGGESTED BY YOUR MEDICAL STAFF AND ADMINISTRATION:

Category 1 Major Emergency Care ____

Category 2 a. General Emergency Care Hospital ____
b. General Emergency Care Hospital ____

Category 3 Basic Emergency Care Facility X

Category 4 Resuscitation & Referral Facility ____

Date NOV. 21, 1972 Signed Roger W. Marquand Title ADMINISTRATOR

support, and otherwise prepare the patient for transport to a Category 1 or 2 hospital for definitive care.

There has been a question of liability in the event of an untoward result in a patient transported to a lower category facility. This has not been a problem in the Statewide system in Illinois, or in other states or cities already categorized. Medicolegal counsel from Squire Sanders & Dempsey in Cleveland indicates this should not be a problem in Ohio. It is recognized that the problems of categorization in rural areas are quite different from the urban multihospital community, for there are several counties in Ohio with no hospital at all, and one county without even a physician!

Many of these small hospitals already do an outstanding job in managing some very serious problems. The intent of categorization is not to reduce their capability or to coerce physicians into sending all serious injuries to a Category 1 or 2 hospital. The need for categorization is to come to some understanding of the capabilities of all hospitals throughout the state and find out where help is needed. Categorization or even providing ambulances is not the panacea for better emergency care, but locating and recognizing problems and discussing them at the community level will provide a start.

Owens-Illinois, Inc. has announced a gift of $300,000 to the Medical College of Ohio at Toledo Foundation in memory of Raymon H. Mulford, former chairman of the company's board of directors, who died last February 9. The Foundation, development arm of the Medical College, intends to use the funds to help purchase some 40 acres of land near the college's new campus.





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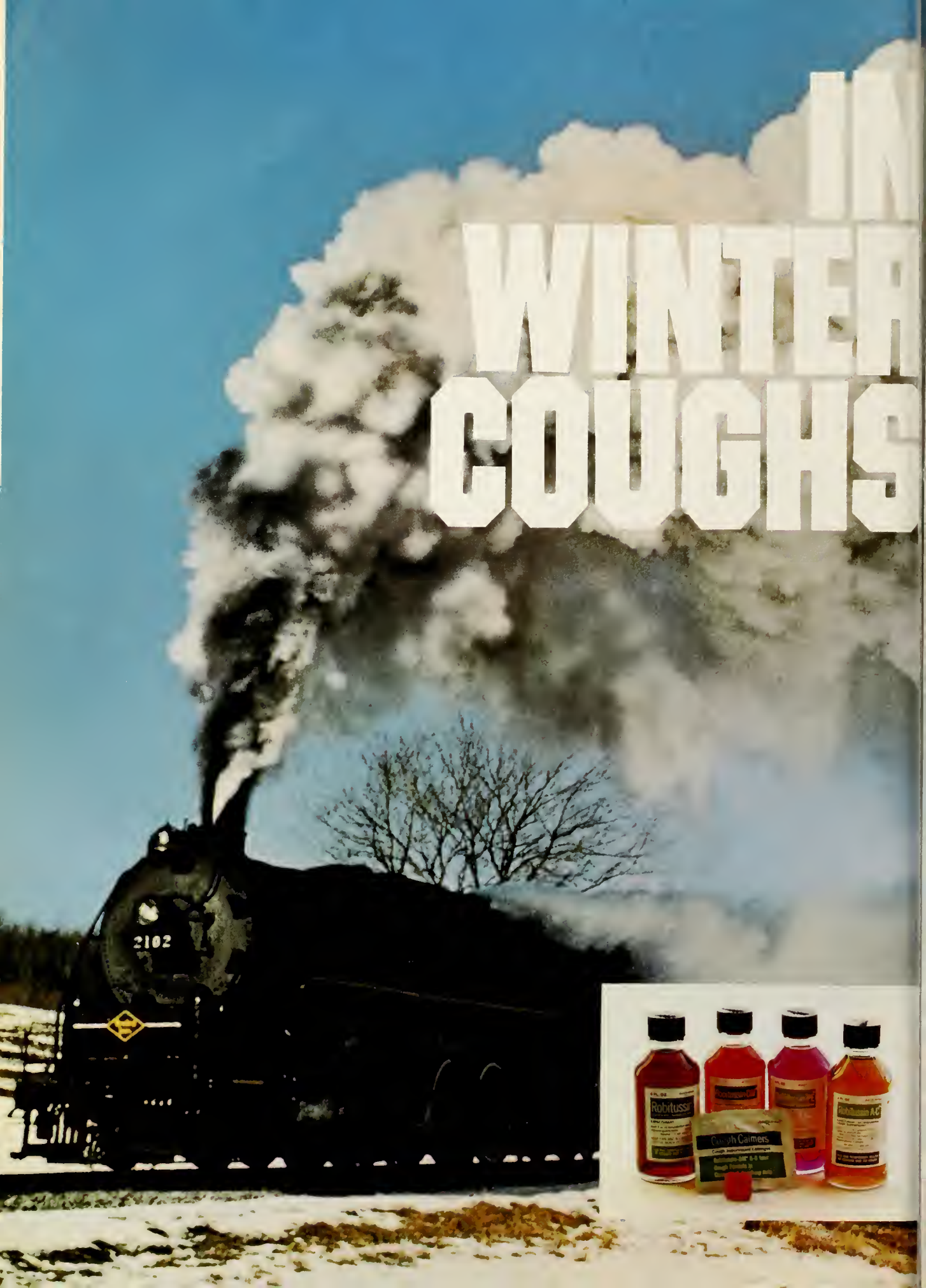
Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP. (equivalent to paregoric 6 ml.) (warning: may be habit forming)	24.0 mg.
Sodium benzoate (preservative)	60.0 mg.
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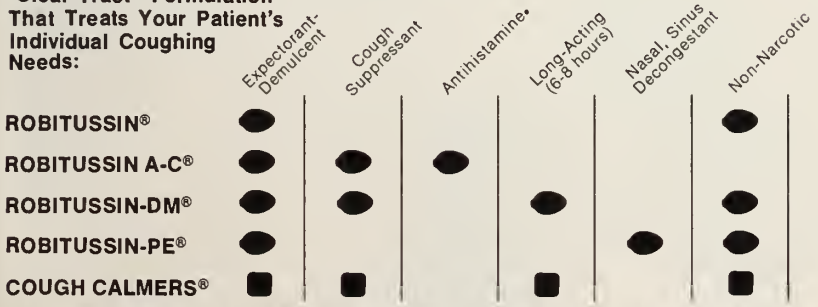
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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatology

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association



Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

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Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent.

Synthroid-T_4

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Deerfield, Illinois 60015



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during November, 1973. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CLARK (Springfield)
Tajuddin Ahmed
Paul E. Andorfer
William S. Harper
E. Gus Mancy

CUYAHOGA (Cleveland)
Pedro C. Anloague, Jr.
Doris A. Evans
Haifa Hanna
Russell W. Hardy, Jr.
Charles B. Hurst, Jr.
Roland S. Philip
Norma N. Reynes
Daniel W. van Heeckeren

FRANKLIN (Columbus, except as noted)
John H. Ackerman
Manuel V. Corpus
Reynoldsburg
Elson L. Craig
C. Deans Crystle
Edward G. Krug
Worthington
Steven H. Lichtblaue
Julian C. Paisan
L. Robert Polster
C. G. Rajmane
Bruce E. Siegel
John S. Wolfe, II

GUERNSEY
Zosimo T. Maximo
Cambridge
Raj Tripathi
Cambridge

LORAIN
Wing Cheong Chau
Lorain

MONTGOMERY (Dayton)
Loren D. Cooper
Franklin S. Danziger
Joaquin Hidalgo
Robert C. Lyons
Lawrence H. Miller

SCIOTO
Ramon O. Malaya
Portsmouth
Yong D. Song
Portsmouth

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during December. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

ALLEN (Lima)
Kirby V. Anderson
Nak-Sup Chung
Thomas E. Dicke
Ronald I. Veatch

BUTLER
James P. Baden
Hamilton

ERIE
B. Ramiro Escobar
Huron
Fred L. Tasker
Sandusky

GREENE
Leonardo Guirnalda
Xenia
Lufti H. Hermina
Xenia

HAMILTON (Cincinnati)
Robert E. Fultz
Albert S. Geller
John L. Houk
James R. Loeb
Tasleem Ahmed Minhas
Suresh B. Patel
David A. Schmid
David N. Tucker
Andrew E. Weiss

LORAIN
Michael C. Kolczun II
Lorain
Oscar Nepomuceno
Lorain

LUCAS
Kenneth A. Kropp
Toledo

MAHONING (Youngstown)
Euhong Kim
Jae Joo Lee
Ramiro E. Verdooren

MONTGOMERY (Dayton)
Yolanda L. Anoos
Otilia J. Asuncion
John J. Hockwalt
James S. Miyashiro
Najwa M. Tabrah
Joseph W. Woods

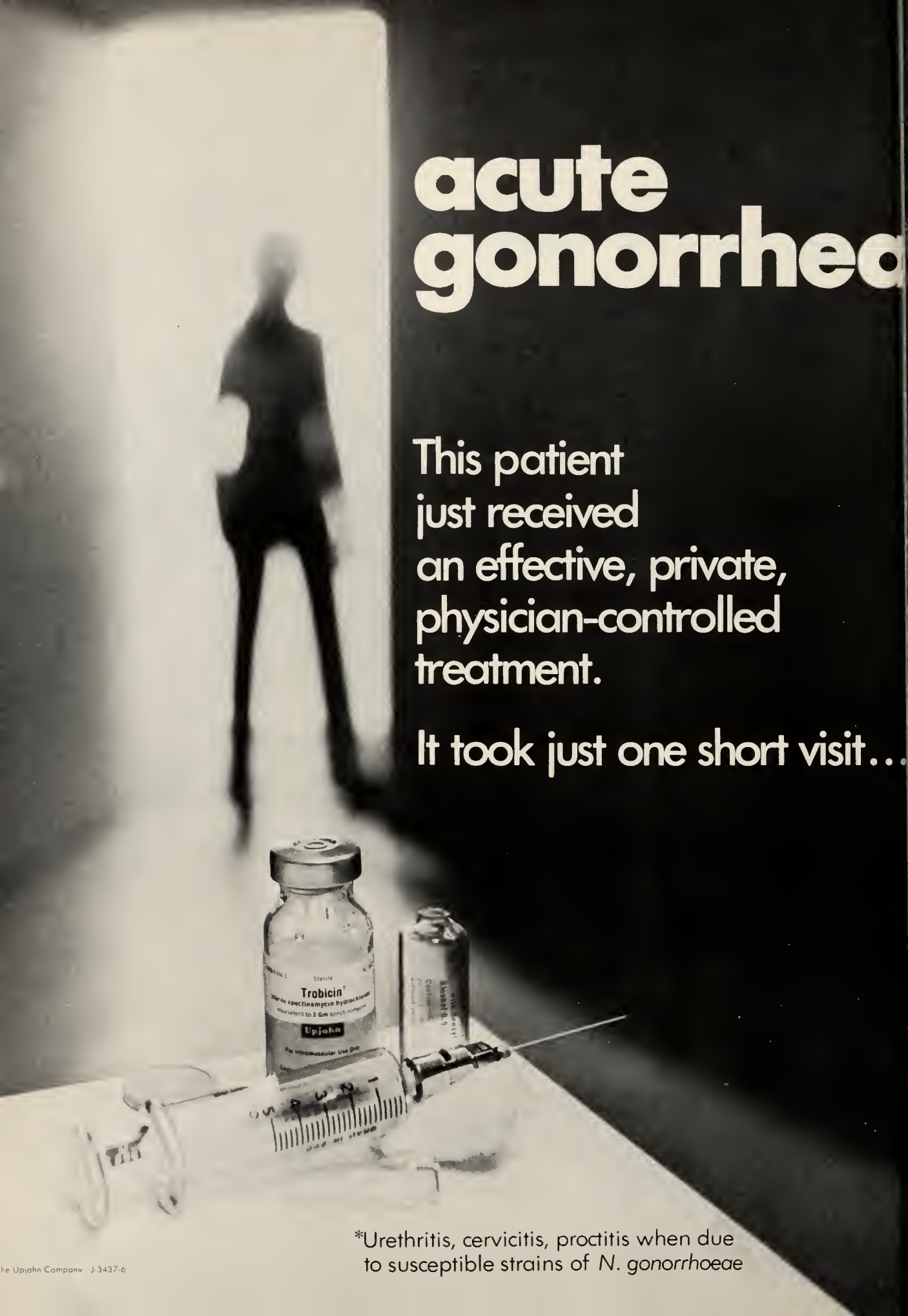
SCIOTO
John Cunningham
Portsmouth

STARK (Canton, except as noted)
Florante L. Briones
Massillon
Eng Seng Chong
Thomas G. DiMauro
Samuel L. Hissong
J. Matthew Neal
Gerald E. Smith
Thurman E. Tobias
S. T. Tonapi
Dieter H. Wilkins
Ronald A. Wittel
Bruce H. Wolf
Edward M. Wurzel

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml) Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin

Indications: Acute ganarrheal urethritis and practitis in the male and acute ganarrheal cervicitis and proctitis in the female when due to susceptible stroins of *N. gonorrhoeae*.

Contraindications: Cantraindicoted in patients previously found hypersensitive to spectinomycin.

Warnings: Nat indicated for the treatment of syphilis. Antibiotics used to treat ganarrhea may mask or delay the symptams of incubating syphilis. Patients should be carefully examined and monthly serological fallaw-up for at least 3 manths should be instituted if the diagnasis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be manitored to detect evidence af develapment of resistance by *N. gonorrhoeae*.

Adverse reactions: The fallawing reactians were observed during the single-dose clinical trials: soreness at the injection site, urticoria, dizziness, nausea, chills, fever and insomnia.
During multiple-dase subchranic tolerance studies in narmal human valunteers, the following were noted: a decreose in hemaglobin, hematacrit and creatinine clearonce; elevotion af alkaline phosphatase, BUN and SGPT. In single- and multiple-dase studies in normal valunteers, a reduction in urine output was noted Extensive renal function studies demonstrated no cansistent changes indicative af renal toxicity

Dosage and administration: Keep at 25° C and use within 24 haurs after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for o 2 grom dose. Potients with ganorrheal proctitis and potients being re-treated after foilure of previous antibiatic therapy shauld receive 4 grams (10 ml). In geographic areas where antibiotic resistonce is known to be prevolent, initiol treatment with 4 groms (10 ml) intromuscularly is preferred.

Female—Inject 10 ml intramuscularly for o 4 gram dose.

How supplied: *Vials, 2 and 4 groms—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9%* w/v. Reconstitutian yields 5 and 10 ml respectively with a concentratian of 400 mg spectinomycin per ml (as the hydrachloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Cautian: Federal law prohibits dispensing withaut prescription.
For additional product information see your Upjohn representative or consult the package insert.

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† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

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IMMEDIATE RELEASE		GRADUAL RELEASE
LIPO-NICIN/100 mg. Each blue tablet contains: Nicotinic Acid .....100 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 5 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/250 mg.** Each yellow tablet contains: Nicotinic Acid .....250 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/300 mg.** Each timed-release capsule contains: Nicotinic Acid .....300 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

WRITE FOR LITERATURE AND SAMPLES

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When the patient on anticoagulant therapy has a condition requiring an analgesic, a new problem arises. Aspirin frequently causes prolonged bleeding time and occult gastrointestinal bleeding.[1,2]

TYLENOL (acetaminophen) however, is unlikely to produce either reaction[2,3] and is therefore the preferred analgesic for the patient with hemorrhagic tendencies and the patient receiving anticoagulant therapy.

The patient on anticoagulants is only one of several 'types for TYLENOL'–that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Koch-Weser, J., and Sellers, E.M.: New Eng. J. Med. *285*:447-458 (Sept. 2) 1971. **2.** Udall, J.A.: Clin. Med. *77*:20-25 (Aug.) 1970. **3.** Mielke, C.H., Jr., and Britten, A.F.H.: New Eng. J. Med. *282*:1270 (May 28) 1970 (corresp.).

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg.
For Children:
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Tylenol® (acetaminophen)

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How to Prepare for an Investigation by the Drug Enforcement Administration

The responsibility for enforcing the provisions of the Controlled Substances Act of 1970 relative to the community pharmacist has been delegated by the Congress primarily to the states. Occasionally, however, the Drug Enforcement Administration will conduct a compliance investigation of a retail pharmacy (or physicians' office). This is done when state authorities have requested assistance; when the pharmacies are selected as part of a special survey to document the abuse of a particular drug; when the pharmacies have been the subject of a specific complaint concerning controlled drug substances; or to determine the nature of the prescribing and dispensing patterns in a particular geographic area.

The foregoing paragraph is the introduction to a detailed release issued by the Drug Enforcement Administration, U. S. Department of Justice. Copies of this release were forwarded by Frank E. Kunkel, executive director of the State Board of Pharmacy, State of Ohio, to state agencies and professional associations concerned with controlled drugs.

Mr. Kunkel stated that some physicians' offices as well as pharmacies and some other facilities are being investigated from time to time.

The following statement is made in the release regarding physicians' offices.

Controlled substances for a doctor's office or his "black bag" are not to be supplied on prescriptions. These supplies must be obtained by the physician by using his own order forms, invoices or purchase requests. A retail pharmacy may supply doctors' needs as long as the pharmacy does not exceed the 5% rule for distribution without a distributor's registration.

Any physician who wishes to receive a copy of the information release may have one by applying to the Ohio State Medical Association office.



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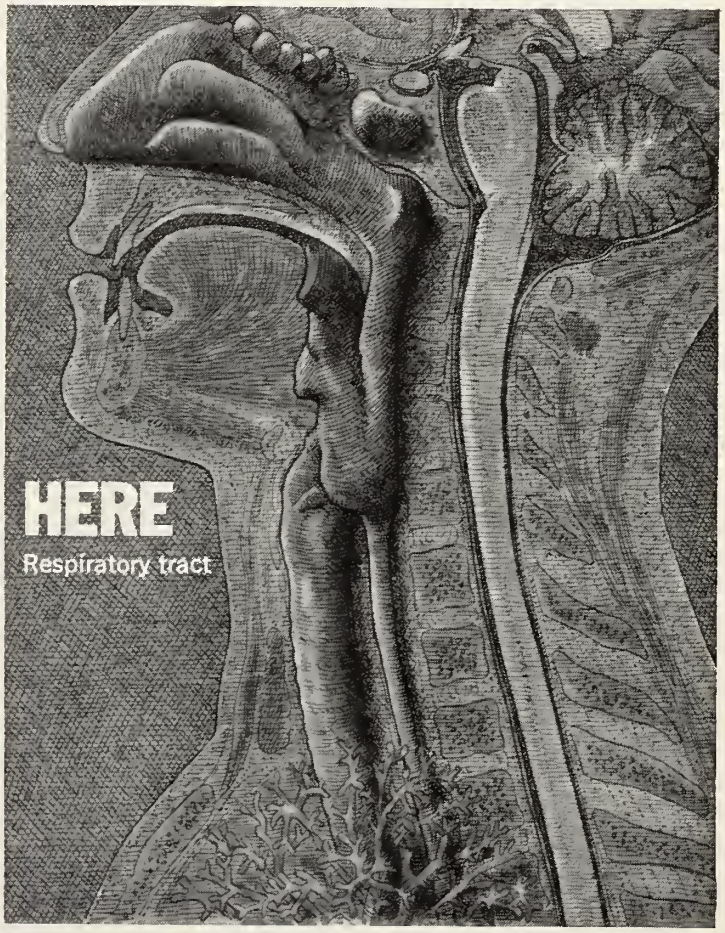
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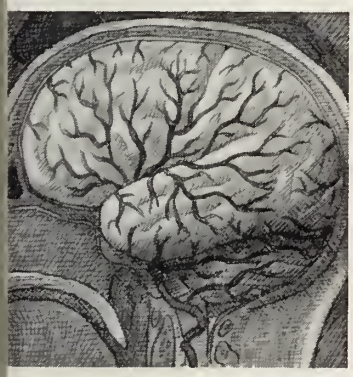
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Continuing Education Opportunities for Physicians in Ohio

February

Pediatric Workshop — Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214, at Hueston Woods Lodge, College Corner (Southwestern Ohio), Feb. 8-10.

Recent Advances in Clinical Psychopharmacology — Sponsored by the Ohio Psychiatric Association, as its Annual Winter Meeting, February 10 at the Marriott Inn, 2124 S. Hamilton Ave., at I-70, Columbus. Gustav A. Batizy, M.D., Program Chairman, 289 Sand Run Road, Akron 44313.

Third Annual Symposium on Clinical Pediatrics, sponsored by Case Western Reserve University, Feb. 12-13. Topic, "Pediatrics, Pragmatism and Pitfalls," includes management problems encountered in medical care of children. Faculty includes Marvin Cornblath, M.D., Frederick Robbins, M.D., and Samuel Gross, M.D., Contact, S. S. Strassman, M.D., Chairman, Pediatric Clinical Faculty, Rainbow-Babies' and Children's Hospital, University Circle, Cleveland 44106.

Common Clinical Problems: Orthopaedic/Neurology — Akron City Hospital, 525 E. Market St., Feb. 20.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Ohio State University College of Medicine, Continuing Medical Education Conferences; for details contact OSU Center for Continuing Medical Education, 410 W. Tenth St., Columbus 43210:

Infectious Diseases — Feb. 6.

Electromyography — Feb. 11-14.

Gastroenterology — Feb. 14-15.

Orthopaedic Problems — Feb. 27.

(Continued on Page 93)



Choloxin®

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See reverse side for full prescribing information and dosage schedule.

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AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased by Increments of	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	monthly 1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	monthly 0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac Patients	0.5-1.0 mg.	monthly 1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following:
Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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Educational Opportunities in Ohio — *Continued*

University of Cincinnati College of Medicine (CONMED); Contact CONMED, 114 Medical College Bldg., Eden and Bethesda Aves., Cincinnati 45219:

Seminar on Gynecologic Oncology — Thursday, February 7, at the Terrace Hilton Hotel, 15 W. Sixth Street, Cincinnati, in cooperation with Upjohn Company; contact CONMED, 114 Medical College Bldg., Eden and Bethesda Ave., Cincinnati 45219.

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106:

Blood Banking — Feb. 6-7.

Current Concepts in Renal Disease and Hypertension — Feb. 13-14.

Diagnostic and Therapeutic Approach to Rheumatic Disease — Feb. 20-21.

Sports Medicine — Feb. 27-28.

March

Ohio State University College of Medicine; for details contact OSU Center for Continuing Medical Education, 410 W. Tenth Ave., Columbus 43210:

Ophthalmology — March 4-5.

Pediatric Clinic Day — At Children's Hospital, Columbus, March 13.

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106:

Advances in Urology, March 13-14.

Refresher Seminar in Pediatrics for Pediatricians and GPs, March 20-21.

Endocrine Pathology — Anatomic and Clinical, March 27-28.

University of Cincinnati College of Medicine (CONMED); Contact CONMED, 114 Medical College Bldg., Eden and Bethesda Aves., Cincinnati 43219:

Annual VA Hospital Symposium, at the VA Hospital, Cincinnati, March 14.

Lederle Symposium — Sponsored in cooperation with the Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214, at the Sheraton-Columbus Motor Hotel in downtown Columbus, March 24.

Ninth Annual Cancer Symposium — Akron City Hospital, 525 E. Market St., March 20-21.

April

Family Relations Work — Sponsored by the Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; place of meeting, Sawmill Creek Lodge, Huron; April 19-21.

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106:

The Challenge of Reconstructive Orthopaedic Surgery, April 3-4.

Infection Control, April 17-18.

Ohio State University College of Medicine, Continuing Medical Educational Conferences; for details, contact OSU Center for Continuing Medical Education, 410 W. Tenth Ave., Columbus 43210:

Spinal Cord Injuries, April 18-19.

Care of the Burned Patient, April 24.

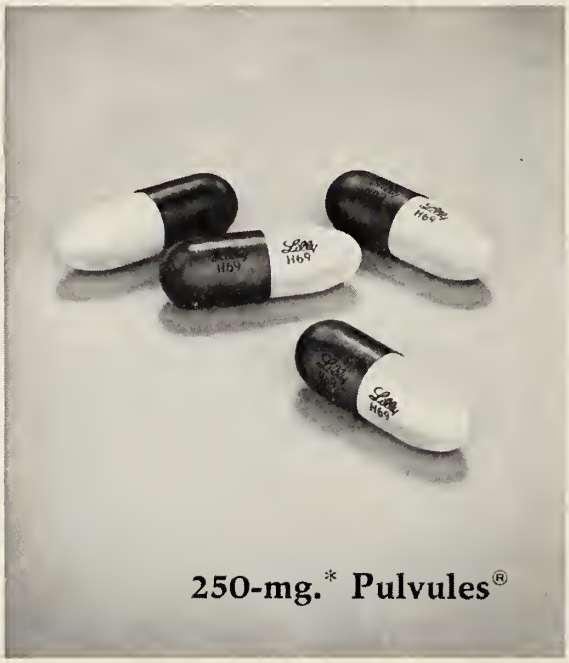
University of Cincinnati College of Medicine, Office of CONMED, 114 Medical College Bldg., Cincinnati 45219:

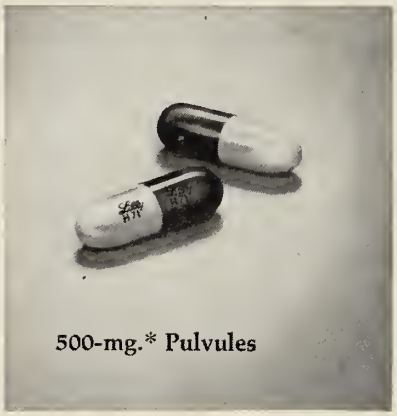
Ophthalmology — Cosponsored by the Ohio Society for the Prevention of Blindness, April 19.

Treatment in Psychiatry—Theory and Practice — At U. S. Brecksville VA Hospital, 10000 Brecksville Road, Brecksville 44141; cosponsored by the Medical College of Ohio at Toledo and Northwestern Ohio Institute for Continuing Medical Education, April 1-5.

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Clinical & Scientific Features



VOLUME 70 FEBRUARY 1974 NUMBER 2

Problems and Prospects for Physician Assistants in Ohio

Experience With the Education of Physician Assistants in Anesthesia in Cleveland

NICHOLAS DEPIERO, M.D.; ARTHUR BARNES, M.D.; J. S. GRAVENSTEIN, M.D.; SIDNEY KATZ, M.D.; STEVEN KOVACS, M.D.; HENRY KRETCHMER, M.D.; KENNETH POTTER, M.D.; FRANCES RHOTON, PH.D.; B. B. SANKEY, M.D.; AND JOHN VILJOEN, M.D.*

THROUGHOUT THE UNITED STATES, and indeed throughout the world, the question has been raised how physicians could increase their productivity and improve their services to patients. Even in the United States, blessed with a relatively favorable physician-population ratio, much dissatisfaction has been expressed and the concept has been advanced that the availability of technical assistants could relieve the physician of certain chores for which he is vastly overtrained. A physician relieved of such burdens could then solve other medical problems now left unattended. Technical assistance could be provided by nurses or physician assistants. Many tasks are outside of nursing and the nursing profession has its own manpower constraints.

These considerations, well-known to the reader of the current medical literature, have their proponents and opponents, both armed with cogent arguments. In the United States, the idea of physician assistants and their value to patients and the medical profession seems to be gaining strength. Several states (29) now have new legislation which permits the physician to delegate certain tasks to physician assistants who work under his direction. In many other states (15) such bills are under consideration.

There is always the question of which tasks a physician could delegate to a nonphysician. It is an important question: On the one hand no task can be delegated to a nonphysician for which a medical school and residency education are required without decreasing the quality of care. On the other hand, any task that does not require this type of education should be delegated if: (A) a qualified individual can be found to execute these tasks and, (B) the employment of such a qualified individual would free the physician to perform other medical tasks.

In order to determine whether or not physician assistants would benefit anesthesiology in Cuyahoga County, a group of Cleveland anesthesiologists invited a team of operations research specialists to examine the specialty, perform task

*All the authors are affiliated with hospitals in the Cleveland area.
Submitted October 16, 1973.

analyses, and make manpower projections. While these studies are not yet completed, all results so far[1,2] indicate that existing manpower constraints can be eased by downward delegation of tasks.

Once the tasks were defined, it became necessary to design a curriculum that would prepare the physician assistants for the task. Such a curriculum had to be educationally sound (ie, it had to be of general and specific benefit to the student) and it had to satisfy the requirements of the specialty.

Educational Requirements

Educational requirements for physician assistants are of two types; theoretical and clinical. In anesthesia, the theoretical components contain certain aspects of physics, chemistry, physiology, and pharmacology. Appropriate clinical education would provide for teaching pertinent clinical syndromes and pattern-recognition skills. The topics and the required depth and sophistication of the didactic material are completely compatible with programs presently available to students in American undergraduate colleges.

The college student of today is sufficiently conversant in physics to understand cardiac dynamics or electrocardiography, and is adequately prepared in biology to deal with the pathophysiology of respiration. Where these subjects are offered to students outside the college setting and structure, the burden to teachers is great, and the process costly and inefficient, since basic education as well as specialty education must be provided.

Other Considerations

Today's high school education is a general one in the sense that it does not, in most cases, prepare graduates for specific jobs. This is also true of the preparation received by current premedical candidates (BS degree in chemistry, biology, and others). As a result, employment prospects for the 50 to 60 percent of medical school applicants who do not gain admission to medical school are grim indeed.

Present solutions for employability also have their attendant problems. Although nursing education or junior college vocational education (inhalation therapy) enhances the opportunities for employment, credits from their specialty-oriented courses (chemistry for nurses) are not readily negotiable with the general university community. Consequently, graduates from these programs find it difficult to progress naturally into classic BS-degree programs, or to more general graduate study.

Case Western Reserve University (CWRU) Program

In an attempt to solve these and other problems, the group of Cleveland anesthesiologists, in association with CWRU, designed a Baccalaureate Degree in Anesthesiology.[3] Specifically, the curriculum was designed to:

1. Lead to a Bachelor of Science Degree in the Health Sciences (Anesthesia). Thus the degree could accommodate other specialties or medically related fields.
2. Meet university standards, insure the qual-

Table 1. Bachelor of Health Science (Anesthesia), a Four-Year Curriculum, Course Requirements (Semester Hours)

General	Hours	Related Field	Hours
English	3	Calculus	8
Social Science	6	Biology	8
Humanities	6	Chemistry (includes organic)	16
Electives	21	Physics	8
Total	36	Total	40

Anesthesia

H.S. 101	Introduction to Medicine Text–Poynter: *Medicine and Man*	2
H.S. 201	Respiratory Physiology Text–Comroe: *The Physiology of Respiration*	3
H.S. 202	Cardiovascular Physiology Text–Guyton: *Textbook of Medical Physiology*	3
H.S. 211 (3)-212(3)	Clinical Laboratories (Correlated with H.S. 201-202) Text–*Syllabi in Progress*	6
H.S. 301	CNS Physiology Text–Guyton: *Textbook of Medical Physiology*	3
H.S. 302	CNS Pharmacology Text–Goodman and Gilman: *The Pharmacological Basis of Therapeutics*	3
H.S. 311(12)-312(12)	Clinical Preceptorship Text–Wylie-Churchhill-Davidson; *Syllabi in Progress*	24
	Total Semester Hours	44

Table 2. Sample Course Content. (Each Roman Numeral Represents One Hour of Instruction.)

Introduction to Medicine (H.S. 101)

I. Organization of living systems and their diseases
II. The nature and origin of drugs

I. History, yield, and status of autopsy
II. Ethics in human experimentation

Pulmonary Physiology (H.S. 201)

I. Work of breathing, respiratory failure
II. Care of respiratory failure patients
III. Ventilators, ventilation strategies

I. Anesthesia and respiration
II. Uptake and distribution
III. Acid-Base I (the first of six hours)

Clinical Laboratories (H.S. 211)

I. Anesthesia equipment
II. Anesthesia circuits

I. EKG and patient monitoring
II. Respiratory care, blood gas analyses

Table 3. Statistical Information on Number of Students and Their Grades in Undergraduate Anesthesia Program

Year	No. Enrolled in H.S. 101*	No. Applying for Program	No. Accepted Into Program	No. of Students Graduating With B.S. in Anesthesia	Grade Point Range†	Mean Grade Point†
1971	35	29	15	7	2.00-3.77	2.91
1972	85	45	15	‡	2.25-4.00	3.10
1973	69	40	15	‡	‡	‡

* H.S. 101 = Required introductory course for all applicants
†1-4 Scale; 4 = best
‡Data not yet available.

ity and transferability of credits and incorporate the requirements of premedicine.

3. Contain sufficient theoretical and clinical instruction to:

(A) Guarantee that graduates have a firm grasp of all concepts necessary to perform immediate anesthesia tasks.[1]

(B) Teach the technical aspects of anesthesia (monitoring equipment, ventilators, and others) in a clinical setting where each student would be guided by individual, practicing anesthesiologists.

4. Make an adequate number of elective hours available to allow students the maximal breadth of education.

The anesthesia program was introduced into the undergraduate colleges at CWRU under the guidance of representatives from the liberal arts colleges, the medical school, biology, dentistry, nursing, as well as the specialty.

The curriculum is summarized in Table 1. Samples of topics taught in selected courses are shown in Table 2.

All candidates must be acceptable for admission to CWRU and must complete H.S. 101 before being considered for admission. Seven students from the first class graduated in June 1973. Of this group, two have gained admission to medical school, all others have become employed at the intermediate level and are now working under the direction of anesthesiologists. Pertinent information on all classes appears in Table 3.

Many students find the program attractive. To date, there have been over 4,500 requests for application information. Other specialties are currently examining the approach.

The Ohio Society of Anesthesiologists has been apprised of the program continuously, has endorsed its concept, and has appointed a "Board of Examiners." This Board has developed standards, established guidelines, and has examined the graduates in August 1973. Successful candidates will receive a certificate from the Board.

In anesthesia, as in other specialties, quality of care can be assured only if all personnel work as a team, and only if the team is directed by the physician with the specialty education that must be available to the patient whenever needed. In order to be available for more medical responsibilities, the physician should delegate to appropriately trained assistants, functions that an assistant can perform as well as (or better than) the physician himself.

Summary

The concept of physician assistants is under examination in many areas of the United States. An educational experiment involving physician assistants in anesthesia has been launched by a group of Cleveland anesthesiologists in cooperation with Case Western Reserve University. The project has been monitored by the Ohio Society of Anesthesiologists and has proved very attractive to students. Of the first students graduating from the program with a baccalaureate degree, two have been accepted into medical school; the others are working in the specialty. A Board of Examiners for this category has been appointed by the Ohio Society of Anesthesiologists.

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The Community and the Institution

Gerhard E. Martin, M.D.

BY NOW, EVERYTHING NECESSARY seems to have been said and written about the services that we need and do not have for the mentally retarded in the community, and the size, structure, programming, and location of the institutions of the future that should, might, or will complement those community services. We have a detailed action policy proposal for the residential services for the mentally retarded by the President's Committee on Mental Retardation,[1] emphasizing living, training, education, recreation, and socialization "as close to the normal way of life as possible in a residential setting." We also have the standards for residential facilities for the mentally retarded by the Joint Committee on Accreditation of Hospitals[2] defining the "ultimate aim of a residential facility to foster those behaviors that maximize the human qualities of the resident, increase the complexity of his behavior, and enhance his ability to cope with his environment."

Numerous scholars have addressed themselves with critical analysis and constructive proposals to details of the "service models" of the future, the radical reorganization of the institutions, and the role of the parents of children that until now have been viewed as special problems who are incidentally human instead of human beings who incidentally have some specialized problems.[3-9]

Last, not least, the existence of more than 30 university-affiliated facilities in this country attests to the fact that all of us have become aware of the pressing need for fundamental changes in our attitudes and practices in the work for and with the mentally retarded. Still, there remains the deplorable state of most of the institutions for the mentally retarded that has become commonplace to all, a concern to many, a challenge to some, and a source of suffering and dehumanization for most of their 200,000 inmates.

Rather than reciting technical aspects of the needed and suggested action, I would like to focus on some of the societal factors which we have to take into consideration with regard to the proposed reforms.

In most discussions of the present sad state of affairs, an attitude has become customary whereby the institutions and their staff are looked upon as the exclusively responsible culprits and as organisms that have separated themselves from the community at their own volition. Whereas it is true, as has been shown by White and Wolfensberger,[10] that influential professionals have been instrumental in bringing about this situation, I would like to think that the community also has all too willingly abandoned the institutions. This appears to be quite obvious when one considers the attitude which led to the establishment of the first institutions, such as expressed in 1889 by Henry Howe in his *History of Ohio:* "The important object of the institution is the amelioration of the condition of the imbecile, the accompanying relief of the family of the burden of care and anxiety for them in their future by so training them that they may attain the greatest possible

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Presented at the Symposium on Life with Dignity, Nisonger Center for Mental Retardation and Developmental Disabilities, The Ohio State University, Columbus, Ohio, November 19-21, 1972.
Submitted August 7, 1973.

degree of self-helpfulness and even usefulness. Fortunately, the rights of the child to its opportunity for education go hand in hand with the sympathies of all in this case. There is no excuse for neglecting them as children that they may be taken charge of when of adult age and size, to be cared for frequently in all respects as infants whose infancy has been prolonged by neglect."

Obviously, then, the task is to reestablish a union between community and institution in order to provide for the most dignified, most appropriate, and most effective services for those who have been stricken without their own guilt.

Residential institutions originally were conceived in a developing industrial society with many low-skilled jobs available, with few mothers working outside the home, with not only the so-called nuclear, but even the extended family largely in existence, with mandatory public education just having been established, with high school education still being developed, and with most people living in rural areas and small towns rather than in large urban and metropolitan centers.

It would seem that the successful habilitation of a great number of trainees in the early small institutions was in large measure related to these characteristics of the society before the turn of the century.

All this has changed. Unskilled jobs are scarce, the extended family is extinct, the continuity of nuclear families is increasingly shaken by a high divorce rate, the gainful work of young mothers outside the home is about to become a civil right and the rule rather than the exception, and academic requirements are making handicapped children much more visible than ever before.

For the retarded child, this will require a need for a new conceptualization of community in terms of where and how he lives, not only now but also later and in terms of what he is being prepared for relative to work, recreation, human bonds, and socialization.

A question that we must face and answer not only from this practical, but also from a moral point of view is: Whose liability and responsibility are those children? Can we demand that a mother and a father care for and raise a severely or profoundly retarded child, or watch over a child with severe behavioral problems all on their own, with nothing but nominal support? Or is it rather not that these parents need the understanding and the support from the community of their fellow citizens? If this is true, then the responsibility for such a child becomes a shared responsibility, at least to some degree.

Let us look at a few of those areas of parental and community concern where the need for sharing of the responsibility seems to be paramount.

Since the type of institutions that we now operate need to be "phased out," we shall do this by looking at the demands and reasons given for inward movement, as well as the implications of outward movement.

A number of workers, notably Maney, et al,[11] Fowle,[12] Shellhaas and Nihira,[13] Allen,[14] and Skelton,[15] have analyzed principal areas of parental needs, the effects of severely mentally retarded children on their families, and the factors that lead to applications for admission and actual admissions to residential institutions. The general impression is that they vary with the age and the degree of mental retardation of the child, with the social class and the composition and the degree of integrity of the family and particularly the locally, quite variable nonavailability of active management community services. More often than not, a family's inability to manage a retarded child is the result of several compounding factors.

Whereas a number of specific prime concerns of the families have been identified, the unifying element of all of these seems to be one of abandonment by the community or, as Shellhaas and Nihira have termed it, a "lack of environmental support."

Mercer[16] has identified as the one most important factor leading to admission to a residential facility and non-re-acceptance a "burden of care" to the point where it assumes a quality and degree that are incongruent with culturally expected and accepted patterns of coping with problems represented by children not necessarily mentally retarded. It is in this situation where both societal demands and expectations placed upon the family and a seemingly consequential absence of community support fuse into a vicious cycle from which the only escape route is the institutionalization of the child involved.

Regarding the outward movement, there is a study by the Department of Mental Hygiene of the State of New York on a representative sample of 1479 residents to determine the appropriateness of continued residency of the 26,190 population of the state institutions.[17] At the same time, the nature and availability of community resources were ascertained for those residents for whom community placement appeared to be indicated. The criteria by which residents were considered appropriate for continued institutionalization or else community placement would appear to be too lenient on one hand and too narrow on the other hand four years later.

Nevertheless, the results of the study give us an idea of both the minimum demands of the presently institutionalized individuals upon the community and the maximum penalization that they suffer. A full 30 percent of the residents were considered suitable for community placement, however, adequate community resources were available for only about a third of these. This would indicate that a solely one-way, though certainly very hu-

manitarian attitude of "let's get them out," is unrealistic as long as a community is not at the same time being helped to consciously accept the appropriateness of community living of mentally retarded individuals and, consequently, provide the necessary services.

As recently as 1967, a nationwide study on public awareness about mental retardation by Henry Gottwald[18] found that virtually 100 percent of the polling sample identified mental retardation with a medical cause, 80 percent held mental retardation incurable, and 50 percent held it unpreventable. Eighty-five percent of those polled would deny a retarded person the right to drink alcoholic beverages, 75 percent the right to drive a car, and 60 percent the right to be downtown alone. Only 2 and 1 percent respectively considered foster homes and day care centers most important.

The New York study showed another dramatic aspect of the present institutionalization practice in that 50 percent of those residents with an IQ from 36 to 51, 70 percent of those from 52 to 67, and a full 85 percent of those from 68 up should and could live in the community and lead a life with a certainly unequivocal and measurable degree of dignity.

Regarding the most pressing and special medical needs of residents suitable for community placement, it would appear all of them could be met in facilities other than a large institution. Specifically needed were on-going medication for behavior disorders and seizures, nursing care, assistance in ambulation, dressing and bathing, and speech therapy. Regarding the needed educational and training programs, a great deficiency in adult education, occupational training, and sheltered workshops was found.

A residential facility, of course, is a place of residence. It appears that it is in this respect that the transition from the institutional resident to the community is most severely hampered. Of those who did have a family, only half of the families were considered adequate for placement. For only a quarter of the residents who would have done well in foster homes, were such homes available and for no more than one-tenth of those who could have led more dignified lives in community residential facilities, such as a halfway house, was such arrangement actually possible.

Conclusion

A full 20 percent of the institutional residents of the State of New York (approximately 6000 persons) could have been placed in the community immediately, if it were not for the sole absence of other suitable living facilities. This represents the vast majority of all those who could not be placed for any number of reasons. In addition, for many (60 percent), essential additional services were not available.

This brief appraisal of some aspects of the inward movement to and the outward movement from the institution provides us with a vivid picture of the dilemma from which we will have to start our efforts toward reform. We will have to be aware of parents in anguish living in a rapidly changing and essentially competitive society, of institutions filled with guilt feelings and very few realistic ways and directions to turn, and of children bearing the consequences of both of them.

It would seem that the very magnitude and nature of our present institutions are a direct function of the absence of community based services. Unless our primary attention is directed toward the creation of these, the situation probably will not change substantially. As long as the sharing in the liability and responsibility for the retarded child does not become a concern of the community, we will not have what we should — true "community institutions."

Summary

Residential institutions for the mentally retarded, presently quite dehumanizing, are to change into facilities that "foster those behaviors that maximize the human qualities of the residents." Whereas the early institutions could discharge habilitated residents into the community fairly easily, modern urban conditions make this much more difficult. This calls for a "shared responsibility" for the mentally retarded who often are not re-accepted by their families owing to a burden of care to the point where it assumes a quality and degree that are incongruent with culturally expected and accepted patterns of coping with problems represented by children, not necessarily mentally retarded.

A study in the State of New York has shown:

1. Thirty percent of institutionalized residents qualify for immediate discharge, but adequate community resources are available for only a third of these.

2. Eighty-five percent of residents with an IQ of more than 68 qualify for discharge.

3. Medical needs for those to be discharged could be, but largely are not, met in the community.

4. Services for adult retardates are particularly insufficient.

5. Half of the retardates' families were considered unsuitable for placement.

6. There is a particular need for the nonfamily living arrangements.

It would seem then that the very magnitude and nature of our present institutions are a

direct function of the absence of community-based services.

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E.N.T. Case of the Month

Andrew W. Miglets, Jr., M.D.*

A 2-year-old infant is brought to your office with a soft cystic swelling located in the posterior triangle of his neck (Fig. 1). His mother noted that this mass has been present for the past year, but only recently began to gradually enlarge.

What is the most likely diagnosis and what form of therapy is indicated?

(See p. 112 of this issue for further information and discussion.)



Fig. 1. This cystic mass in posterior triangle of neck has been gradually enlarging.

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Submitted September 5, 1973.

Medical Education Workshops

A Study of Their Influence on Teaching Behavior of Medical College Faculty

William C. Farr, M.D., and Mary Heider, Ph.D.

THREE, THREE-DAY workshops for faculty and Regional Medical Program (RMP) members on educational planning in the health sciences were given. The workshops were designed to meet the expressed needs of some faculty for assistance and training in teaching methodology. A "home-team," University of Cincinnati Medical School faculty, initiated the workshops; each member had previously attended workshops held by the Center for Educational Development (CED) at the University of Illinois College of Medicine, Chicago. Two CED staff members, along with the Cincinnati faculty, planned the workshop objectives; the CED staff designed the actual workshop curriculum.

The workshop objectives were as follows: Upon completing the workshop, a faculty member will be able to (1) state his objectives in behavioral terms, (2) develop sequences of learning activities for specified objectives, and (3) analyze the teaching of others.

Workshop groups were small (13 to 20) and an informal, nonjudgmental atmosphere was established from the beginning. A sequence of learning experiences was designed so that the participants were able to develop ideas in small groups (two or three) and then share them with the entire group. The staff presented basic concepts, encouraged and directed discussion, and acted as resources, but no actual lectures were delivered.

The workshop series was funded by Public Health Service grant L-5445.
Submitted July 23, 1973.

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Emphasis was placed on helping participants apply theory to practice in their own field.

The first two days were devoted to (a) identifying characteristics of desirable learning experiences and discussing how these characteristics could be incorporated into effective teaching; (b) sequencing learning activities to achieve a given outcome; (c) writing instructional objectives in behavioral terms; (d) analyzing the teaching performance of a person on video-tape; and (e) using the principles developed to plan a ten-hour curriculum in the participant's field of interest.

The third session, a microteach, occurred one week later. In this, each participant conducted a ten-minute learning experience of his choosing; this was video-taped. The participant received immediate feedback from a peer group (four or five) and one staff member; he then viewed his video tape, revised the ten-minute session, and pre-

sented it again to a second peer group and an instructor.

The Cincinnati medical faculty who conducted the workshops were Doris G. Beatty, Associate Professor of Medicine and the writers. All are engaged in their own professions and are not professional workshop leaders or "educationalists." The expert staff from CED (our teachers, coplanners, and coaches) were Mary Wise and Karen J. Connell.

Letters of invitation were sent by the Department of Biomedical Communications to the medical faculty inviting them to attend the workshop. Sessions were held away from the medical center.

Purpose of Study

The objective of this study is to evaluate the effectiveness of the workshops in producing change in five selected areas of participant teaching behavior in a short time following the workshop. Each behavior was chosen because it was considered important for quality medical education. A set of minimal requirements for participant learning and change in the five behaviors was established.

The participants' use of instructional objectives was evaluated first. This category was subdivided into two parts: (1) Did the participant adopt instructional objectives? Presentation of course objectives (written or verbal) by the participant to his student was used as minimal evidence of change. Proof was not required that the objectives be behavioral; writing true *behavioral* objectives was considered a more advanced learning not to be expected at this time. (2) Did the participant show an attitude change of focusing on student outcomes (behavior) rather than on the content of the subject to be taught? Outcomes or behaviors refer to measurable actions in either the cognitive, affective, or the psychomotor domain. Minimal evidence of change required the participant to report giving greater emphasis to student outcomes in his teaching.

Next, a check was made to determine whether a teacher had changed any of his methods of instruction as a result of attending the workshop. Did he utilize new sequences of instruction to reach his objectives? Any use of varied teaching activities in addition to chalk and slides (eg, varies sequence, uses handouts, has problem-solving, improves lecture skills) was considered minimal evidence of change.

Two other changes were evaluated: As a result of attending the workshop, had the participant solicited new forms of feedback on his teaching performance? The minimal requirement for change was the incorporation of at least one formal means of feedback from students or colleagues not used in the past. Finally, had the participant communicated with fellow faculty about the teaching process? The minimal requirement was that he reported discussing teaching processes with a colleague and/or analyzing the teaching processes of others.

Data Sources

Two sources were used to obtain data on the five teacher behaviors chosen for evaluation:

(1) *Questionnaire.* A questionnaire designed to obtain data on participant change was sent to each group of participants 14, 12, and 5 weeks after completion of the three respective workshops. The questions asked are shown in Table 1. A validity check was conducted on the questionnaire by interviewing one third of the respondents. Each participant was asked to verify our interpretation of his questionnaire responses.

(2) *Participant Contact.* Any interaction between staff and participants involving discussion of teaching methods, reports of changes in teaching, or requests for help were included under contact.

Data Analysis. A participant was rated "successful" if he showed at least one piece of evidence (obtained from the questionnaire or contact) that he had made a change in a particular teaching

Table 1. Educational Workshop Questionnaire Items

For the following seven items, participants were asked to check, with regard to the following activities discussed in the workshop, if they (a) adopted the activity since the workshop, (b) did the activity prior to workshop, (c) did activity prior to workshop and revised since workshop; no response was also tabulated:

1. Write out learning objectives for the entire course.
2. Write out learning objectives for each lecture.
3. Distribute the above objectives to students.
4. Use a new sequence of activities in your lectures.
5. Incorporate student activity or student interaction in the lecture hall.
6. Allow students to ask questions during the lecture.
7. Use feedback sheets for evaluating yourself as a lecturer or students' understanding of lecture content at each lecture.

For the next four items, participants were asked to circle if they had engaged in the behaviors since the workshop (a) about the same as before the workshop, (b) somewhat more than before the workshop, (c) much more than before the workshop; no response was also tabulated:

8. Talked with others about your teaching activity.
9. Talked with others about teaching methods in general.
10. Analyzed the teaching *process* of others.
11. Asked peers for feedback about your teaching.

Three open-ended questions were included:

12. Have you had any different approaches to teaching or made any changes in your teaching since the workshop?
    Please check: Yes____ No____
    If answer is "yes," please list or briefly describe changes.
    If answer is "no," briefly explain why.
13. List or briefly describe any changes you have made as a result of the microteach feedback.
14. List any other major changes made as a result of participation in the workshop.

behavior since attending the workshop. If the participant had engaged in the behavior prior to the workshop, but had *revised since* the workshop, this was also taken as evidence of "success."

Results

Participants. Forty-six faculty members attended the three workshops. There were three department heads, 17 professors, six associate professors, eight assistant professors, four nursing faculty, three RMP representatives, and five graduate students. Thirty-four (74 percent) responded to the questionnaire. Of these respondents, 25 were able to attend the microteach sessions.

Change in the Five Teaching Behaviors. Table 2 shows the percent of workshop participants who provided minimal evidence of a change in each of the five categories of teacher behavior examined. The data are expressed by primary area of teaching activity. All graduate students were teaching and are listed in the basic science category. Eleven respondents showed evidence of changes in all five categories, eight in behavior 4, six in behavior 3, three in behavior 2, and three in the one category. Three respondents showed no change at all.

The validity check results showed total agreement between questionnaire responses and interview responses for behaviors 1, 2, and 5. (See Table 2.) Differences were found for behaviors 2 and 4. These differences were checked with a test for significance of proportion[1] to determine if they were statistically significant; they were not ($z=0.60$ and 1.20 respectively).

Discussion

The purpose of this study was to determine if a workshop on educational planning can be a viable tool for producing a change in teacher behavior. Over one half (19 of 34) of all respondents showed evidence of change in four of five behaviors studied. Communications about teaching showed the most striking increase (85 percent); this is in keeping with the expected first step of affective change – awareness.[2]

Sixty-five percent of respondents had adopted since, or revised, their use of instructional objectives after attending the workshop – a necessary initial change.

The use of varied teacher activities in addition to chalk and slides was emphasized in the workshop, and 68 percent stated they had utilized new approaches to instruction. Examples cited were using problem-solving, incorporating new audio-visual devices, posing questions for student discussion, distributing problem work sheets, increasing class-instructor interaction during lectures, providing demonstrations, and other examples.

The importance of feedback was stressed in the microteach sessions. Seventy-six percent of the respondents provided evidence in the questionnaire of incorporating new feedback mechanisms. However, this may be inflated because the validity check showed that 4 of 11 interviewed had not changed even though they reported the opposite on the questionnaire. This might be interpreted as an indication of participant awareness of the need for feedback while reflecting their hesitancy to take the risks involved when soliciting feedback.

The area of least change (41 percent) was in the extent to which teachers placed greater emphasis on student outcomes rather than on course content. This may mean that some teachers find it difficult to make rapid changes away from the content-oriented lecture format toward the use of behavioral objectives and new implementation processes.

The smallest change in adopting a student-outcome orientation occurred in the clinicians (25 percent) as compared to 50 percent for basic scientists (Table 2). The data are based solely on information from open-ended responses in the questionnaire. The validity check for this behavior showed no significant difference between questionnaire and interview responses, but two people reported adopting a student-outcome orientation in the interview but not on the questionnaire. More

Table 2. Percent of Workshop Participants with Minimal Evidence of Change in Five Teaching Behaviors

No. Faculty	Basic Science 22*	Clinical Science 12*	Total 34	% Changed
Teaching Behavior				
1. Has objectives	14	8	22	65
2. Is student-outcome oriented	11	3	14	41
3. Uses varied activities	14	9	23	68
4. Seeks feedback	16	10	26	76
5. Discusses teaching	19	10	29	85

*Includes total attendance of three workshops.

positive responses would likely have been identified had a structured item been incorporated originally.

Although the sample is small, this apparent difference between clinical and basic science teachers could simply mean that clinicians have not become oriented toward student outcomes in teaching; or more likely it may indicate that clinicians have already adopted such an orientation because of the fortuitous influence of the clinical environment on their teaching. A student and clinician work in a setting where learning and application go hand in hand. Differences in the instructional attitudes of basic science and clinical science teachers need to be further explored.

Of particular interest is the fact that the changes discussed here have occurred in only 5 to 14 weeks since the workshops. The ultimate success of such workshops needs to be further confirmed by direct study of teacher behavior in the classroom.

Finally, the data indicate that educational workshops can be a vehicle for change in a responsive faculty. Furthermore, in the absence of a medical education department, peer instructors can staff such workshops. Continued faculty change will require additional workshops to reinforce as well as provide new educational experiences.

Implications for Medical Education

The effects of an educational workshop on the quality of medical education can be far reaching. Yet the ultimate success rests on the effort each faculty member expends in improving his daily teaching activity. Clearly defined objectives, particularly when considered in the framework of what a student should be able to do upon finishing a course, can increase the effectiveness and relevance of a teaching program for both student and teacher. A teacher who has learned to ask himself, "why do I want to teach this material, and will it contribute to my objectives," has truly taken a giant step from the time-honored pedagogy we all have practiced in one way or another — content-oriented teaching. He has identified his goal and, thus, increased his chances of reaching it.

When combined with feedback, selective use of varied teaching methods can only help improve and not detract from the end product. Feedback can (1) solicit constructive criticism relevant to the teacher's goal *product* and (2) seek information on the success of the course *process* as well as content. Varied methods of obtaining feedback can be incorporated; no longer must a teacher depend solely upon the time-honored, "mellowed-over," end-of-course, feedback questionnaire upon which so many of our current teaching problems have been promulgated. Furthermore, the interaction among faculty, discussing, questioning, rejecting, accepting, and "critiqueing" the process of teaching can help us all to better understand what it is we're about!

Summary

Three three-day workshops on educational planning in the health sciences were offered to the medical faculty at the University of Cincinnati and the Regional Medical Program staff. Workshops were planned and conducted by three faculty members assisted by Center for Educational Development staff.

In a questionnaire study, 5 to 14 weeks after the workshops, over 55 percent of the respondents reported they had changed in four of five areas of teaching behavior evaluated. Eighty-five percent had discussed teaching with a colleague or had more keenly observed the teaching of others. Seventy-six percent had varied their teaching activities. Sixty-five percent presented course objectives or revised previous ones. Least change (41 percent) occurred in focusing on student outcomes (behavior) rather than solely on content. Differences were identified for basic science faculty and clinical science faculty. It was concluded that a three-day workshop in educational planning presented by medical faculty can influence fellow faculty to change teaching behaviors in a relatively short time.

Acknowledgment: We acknowledge the help of Philip G. Bashook, Ed.D., Research and Evaluation Section, Center for Educational Development, University of Illinois College of Medicine, Chicago; and the support of Gunter Grupp, M.D., Chairman, Department of Biomedical Communications, University of Cincinnati College of Medicine.

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Hydrothorax Complicating Subclavian Vein Infusion Therapy

A Case Report

Stewart P. Chase, M.D.

AN UNUSUAL COMPLICATION of subclavian vein intravenous infusion therapy is the rapid development of a large unilateral hydrothorax following placement of the polyethylene catheter into the pleural space instead of the subclavian vein. The physician, being aware of this potentially serious complication, can make an early and possibly lifesaving diagnosis.

Case Report

A 3-½-year-old white girl with a tracheoesophageal fistula was admitted to the University of Kentucky Hospital for definitive surgical repair. She had been hospitalized many times previously. She was a somewhat underdeveloped child weighing 12.3 kg (27 lb) with rectal temperature 37.4 C (99.4 F), pulse 120 beats per minute, respirations 30 per minute, and blood pressure 110/68 mm. Hg. A gastrostomy was present and the proximal esophageal segment was fistulized into the neck.

On September 10, 1970, the patient was taken to surgery for colonic interposition. During surgery, a left subclavian intravenous infusion was started. A postoperative, portable, supine radiograph of the chest (Fig. 1) taken at 5 PM showed the coiled polyethylene catheter projecting over the left infraclavicular area. No pleural fluid could be seen at that time. During the next 24 hours, the patient became progressively dyspneic and cyanotic, and another portable radiograph of the chest was obtained (Fig. 2) on September 11 at approximately 7 PM. A large hydrothorax could be seen on the left, with shift of the mediastinum to the right. The polyethylene catheter again projected over the left infraclavicular area.

The diagnosis of hydrothorax due to infusion of fluid into the pleural space was made, the catheter was removed, and 450 ml of clear pink-tinged fluid was removed from the left pleural space by thoracentesis. The patient's dyspnea and cyanosis immediately cleared, and a post-thoracentesis portable radiograph of the chest (Fig. 3) showed clearing of the hydrothorax and return of the mediastinum to the midline. Subsequently, no further fluid accumulated.

Discussion

The complications of subclavian intravenous infusion therapy include thrombosis, thrombophle-

Submitted July 9, 1973.

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Fig. 1. Portable postoperative radiograph of chest taken at 5 PM, 9/10/70 showing polyethylene catheter coiled in left infraclavicular area.

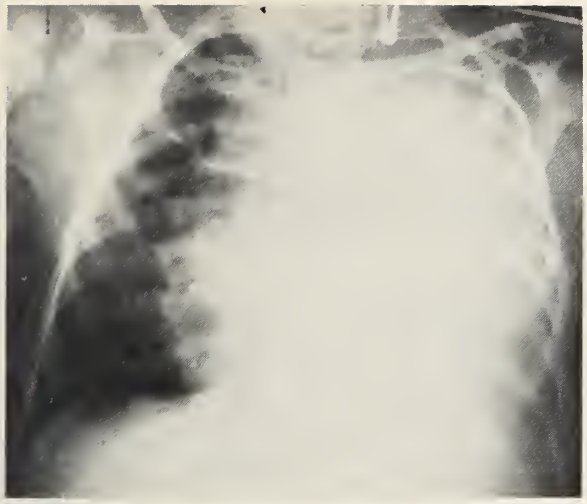


FIG. 2. Portable radiograph of chest taken at 7 PM, 9/11/70 showing large left-sided hydrothorax and shift of mediastinum to right.



FIG. 3. Portable radiograph of chest taken after removal of catheter and 450 ml of pleural fluid by thoracentesis.

bitis, hematoma, pneumothorax, hemothorax, and hydrothorax. Hydrothorax is the least common of the complications, occurring in 0.5 to 2.0 percent of cases.[1] Chronic pulmonary disease is a relative contraindication to subclavian vein catherization, and bilateral infusion is inadvisable.

The term "tension hydrothorax" has been used in referring to large accumulations of pleural fluid under pressure,[2] having the same serious prognostic implications as a tension pneumothorax. The patient described seems to be an example of this condition. There have been several previous reports of cases similar to this [3,4] however, because of the potential danger of this complication, and because the physician can make an early and possibly lifesaving diagnosis, it is worth re-emphasizing this complication of subclavian intravenous infusion therapy. A rapidly developing hydrothorax or pleural effusion, in the presence of a subclavian infusion catheter, should suggest the diagnosis.

Summary

A case of hydrothorax complicating subclavian infusion therapy is described. A series of radiographs showed a rapidly developing hydrothorax in the presence of the radiopaque polyethylene catheter. Awareness of this serious complication can lead to an early diagnosis.

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Abortion and Red Rubber Catheters

A Case Report and Discussion

Amrutha Bhakthavathsalan, M.D., and Melvern A. Ayers, M.D.

THE URETHRAL CATHETER seems to have been a particularly popular abortive instrument. These are occasionally lost during the procedure resulting in foreign bodies anywhere in or out of the pelvis. With the easy availability of contraceptives and legalized abortions, recent reports of foreign bodies thus found are comparatively rare. Diagnosis and treatment of septic abortion with or without associated gram-negative septicemia are widely reported and discussed, but the management of a case of attempted abortion with a foreign body lost inside is different in certain respects. One such case report is given. The outcome of pregnancy in such cases, the ultimate fate of the foreign body left behind, and the diagnosis and management of similar cases is discussed.

Case Report

A 26-year-old single Negro woman, gravida 3, para 2, came to the emergency room on April 21, 1972. She complained of abdominal pain, nausea, and vomiting gradually increasing in severity since April 17, 1972. Her last menstrual period (LMP) was December 26, 1971. After some questioning, she admitted that about a week before an "abortionist" had introduced a rubber "tubing" into her womb and told her that she would abort in 48 hours. She did not abort nor did the tubing come out. Meantime, her condition had gradually worsened.

Her two previous pregnancies were uneventful.

On examination, she was of average build, acutely ill, and in pain. Her temperature was 37.6 C (99.8 F), blood pressure was 124/70 mm Hg, and pulse rate was 108 beats per minute. Her abdomen was very distended and tender throughout. Bowel sounds were absent. A pink discharge was noted in the vagina. The cervix was closed and soft with the uterus about 12-weeks size. No adnexal masses were palpable. Marked pelvic tenderness was present. Cultures were obtained from the cervix.

The hemoglobin value was 12.1 gm per 100 ml, the hematocrit reading 35 percent, and the white blood count (WBC) 19,000 per cu mm, with 92 percent segmented neutrophils. Urine pregnancy test was positive.

X-ray films of the abdomen showed a radiopaque rubber catheter lying partly in the pelvis with one end in the right lower quadrant, obviously outside the uterus (Fig. 1). There was evidence of paralytic ileus with several air fluid levels in the small bowel.

Therapy with intermittent Levine suction, intravenous fluids, and Keflin was started. Two units of blood were crossmatched, and surgical laparotomy was performed under general anesthesia. On opening the peritoneal cavity, a small amount of serosanguienous fluid was found. Smear and culture of this were obtained. A red rubber catheter was found lying in the peritoneal cavity in the right lower quadrant adherent to loops of small intestine. The other end of the catheter protruded through a small perforation in the posterior aspect of the uterus, near the fundus (Fig. 2). During manipulations to free the intestines, this end came out of the uterus which looked pink, soft, and otherwise healthy. No discoloration or other trauma was noted. The small perforation was closed with a couple of 3-0 chromic catgut sutures. The fibrinoid bowel adhesions were released easily, and the catheter was removed. The intestines were carefully inspected and no perforations or other trauma were evident. The abdomen was closed and drained.

Several hours postoperative, the patient started heavy vaginal bleeding and spontaneously expelled a male fetus of approximately 16-weeks gestation. Pitocin was added to the intravenous fluids, and two hours later, she expelled the placenta. Dilation and curettement was deferred because of the recent perforation in the uterus. She was continued on treatment with oxytocics.

The patient received two units of blood because her hemoglobin value dropped to 9 gm per 100 ml. She became afebrile, the ileus cleared, suction was discontinued, and clear liquids were started orally. Bowel movements started on April 26, 1972.

But at this point, temperature began to spike again. There were large amounts of drainage through the Pen-

Submitted August 14, 1973.

The Authors

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- **Dr. Ayers, Toledo, is Director, Obstetrics and Gynecology, Toledo Hospital.**

rose drain. *Bacteroides* infection was considered despite no growth in the peritoneal fluid. Treatment with Chloromycetin, 500 mg every six hours, was started. The temperature returned to normal in 48 hours. On April 28, 1972, a small piece of necrotic placental tissue was passed. The Penrose drain was removed on May 2, 1972.

She was discharged home on May 6, 1972 in good condition with the abdominal wound clean and healing well.

Comment

Metallic and nonmetallic objects used for abortion often have been lost inside. The great diversity of foreign bodies thus found is said to be limited only by their availability and by the patient's imagination as well as, perhaps, her state of desperation.[1] Most commonly, these objects are introduced into the cervix but occasionally, due to poor anatomic knowledge, they may be pushed into the urethra instead and end up in the bladder.[2] In the uterus, this foreign body usually causes abortion, but occasionally it may be retained for varying lengths of time including being expelled with a term fetus.[1] A hard, irregular, or grasping object may cause extensive damage not only to the uterus but also to the surrounding viscera. The soft rubber catheter is obviously not so damaging and probably this is why it is so popular with the untrained abortionist. The soft gravid uterus may be perforated even by a soft rubber catheter.[1,3-7] but,



Fig. 1. Flat plate roentgenogram of abdomen showing rubber catheter.



Fig. 2. Perforation in posterior aspect of uterus near fundus as seen at laparotomy.

in these cases, the damage is usually minimal. The outcome of pregnancy in these cases is usually abortion,[1,3] but surprisingly, there have been quite a few reports of pregnancy proceeding to term and uneventful delivery after the catheter is removed from the abdomen.[4,6,7] It is surprising how much damage a pregnant uterus can stand occasionally. In the case of Green, Pahigian, and Reid, after traumatic perforation, probably criminal, of a 10-week pregnant uterus with herniation, strangulation, and gangrene of small bowel and evulsion of the mucosa, surgical repair was done. After this, pregnancy went to term and a healthy, 3.7-kg (8 lb 4 oz) infant was delivered vaginally.[5] A nonpregnant horn may be curetted or perforation may occur in between the two horns with a normal pregnancy outcome.[8]

A "lost" object prompts the patient to seek early medical aid. With prompt surgery, minimal peritonitis is found. The foreign body may lie free in the peritoneal cavity, but it can erode or perforate into other viscera, retroperitoneal spaces, or rarely into a blood vessel.[1] Occasionally, these foreign bodies may be forgotten and remain for long periods resulting later in unexplained abscesses or sinuses in different parts of the body.[9]

To prevent undesirable sequelae, early diagnosis and prompt treatment are essential. History is very important, but sometimes the patient may not reveal the facts. Pelvic examination may sometimes reveal a foreign body,[3] but otherwise, findings are very similar to septic abortion with peritonitis. Usually the foreign body is radiopaque. X-ray examination should include the entire abdomen. Determination of location is essential. If the foreign body is in the bladder, it can be removed by cystoscope. Inside the uterus, it can be removed by dilation and curettement or hysterectomy.[3] Sometimes a foreign body may not show

on an x-ray film. Therefore, in septic abortion with peritonitis without improvement, or with suspicion of damage to internal viscera, exploratory laparotomy is definitely indicated. The surgeon must look in the peritoneal cavity, inspect viscera, and search the retroperitoneal space.[1] If not closed by omental adhesions or exudate, the uterine perforation may be sutured with catgut. We suggest draining the peritoneal cavity as indicated. If a catheter should be lying with one end in the vagina and the other end in the peritoneal cavity through the uterus, we suggest dividing the catheter at laparotomy at the level of the uterus with removal of the upper part from above and the lower part from below. Only in cases of extensive damage to the uterus is hysterectomy necessary. No attempt should be made at this stage to empty the uterus unless indicated by sepsis or hemorrhage. Usually spontaneous termination of the pregnancy occurs.

Early diagnosis, a careful search for damage, and conservative surgical management with antibiotic coverage should provide a successful treatment program.

Summary

The soft rubber catheter seems to have been a particularly popular tool used by the abortionist or the woman herself in an attempt to procure abortion. Occasionally, these have been "lost" leading to very unusual sequelae. Diagnosis and management of foreign bodies in attempted abortion may present other-than-usual problems.

Generic and Trade Names of Drugs
Sodium cephalothin — Keflin (Lilly)
Oxytocin — Pitocin (Parke-Davis)
Chloramphenicol — Chloromycetin (Parke-Davis)

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When the Serum Sodium Is Low

Leonard B. Berman, M.D.*

SERUM SODIUM concentrations have become a part of every patient's hospital record. Interpreting them correctly depends on two fundamental facts. First, a concentration is a *ratio,* ie, the amount of sodium compared with the amount of plasma (plasma water) in which it is dissolved. Thus, an abnormal value may result from a change in the amount of sodium, or a change in the amount of water, or a change in the amount of both. This leads to situations which all have a low serum sodium concentration, but arise from different mechanisms and call for different treatments. The second key fact is that the serum concentration of sodium does not measure the concentration inside the cells and other special compartments such as bone. It is possible, therefore, for serum sodium concentration and total body sodium to vary in opposite directions.

The two most common types of hyponatremia are illustrated in the following table:

	Serum Sodium	Body Sodium	Body Water	Give Sodium
1. Depletional	low	low	low	yes
2. Dilutional	low	high	high	no

Depletional hyponatremia is diagnosed by the combination of hyponatremia and dehydration. There is usually a history of gastrointestinal loss, or less commonly, the sodium is lost in the urine (Addison's disease or various forms of chronic renal failure). Both the dehydration and the hyponatremia are rationally treated by the administration of salt and water. On the other hand, *dilutional* hyponatremia is seen in a patient with edema. Treatment here is the mobilization of edema, rather than giving sodium to an already salt-rich body fluid.

There are several interesting, less common types of hyponatremia:

1. Inappropriate ADH
2. Water intoxication
3. Drug induced hyponatremia
4. Hyperlipemic hyponatremia
5. Mixed disturbances involving dehydration and edema in the same patient

The diagnosis of inappropriate antidiuretic hormone secretion is important for two reasons. First, it points to an underlying disease, for example, bronchiogenic carcinoma; and second, it requires no treatment. Acute water intoxication is seen in the patient who ingests or receives intravenously very large volumes of water over a very short period of time. There is an abrupt change in sensorium and sudden hyponatremia. The aim of treatment is to restore the osmotic pressure of extracellular fluid by hypertonic saline. The third category, drug induced hyponatremia, includes the thiazide diuretics and also the oral antihyperglycemic agent chloropropamide. Treatment consists of removing the offending drug. Hyperlipemic hyponatremia illustrates an interesting fact about sodium, ie, that it is contained within the water portion of plasma. This constitutes only 93 percent, the other 7 percent of the plasma being protein. With a high concentration of lipids combined with proteins, there is even less water in the plasma. The concentration of sodium is low when expressed per unit of plasma even though the sodium concentration of plasma water is quite normal. The diagnosis is made by observing a normal serum freezing point depression (osmolality). The best example of the fifth category is the patient with cirrhosis and ascites who appears dehydrated

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Submitted July 26, 1973.

peripherally and whose serum sodium may be extremely low in the face of a depressed sensorium. The clinician must resist what seems like an obvious need for an acute elevation of serum sodium. Most of the time the administration of hypertonic saline does no good.

Thus we have the diversity of the clinical puzzle that is hyponatremia. When the serum sodium is low it requires the simple facts of the history and physical examination, combined with a conceptual framework to make the correct therapeutic decision. The treatment of hyponatremia may be the administration of salt, the withholding of salt, the cessation of an offending drug, or the realization that no treatment is necessary, beyond looking for the underlying cause.

Discussion of E.N.T. Case of the Month

(continued from p. 101)

Cystic lesions of the neck in children can be divided into two major categories. Those of branchiogenic or thyroglossal tract origin will occur along the anterior border of the sternocleidomastoid muscle or in the midline of the neck. The other major type of cystic lesion (cystic hygromas) arises from an abnormal development of the jugular lymphatic sac in the embryo. These may occur anywhere in the neck, or pharynx and characteristically form unilocular or multilocular, endothelial-lined, fluid-containing cysts. Cystic hygromas are present at birth in over half of the children affected and are usually symptomatic by the second year of life.



Fig. 2. Surgical exposure revealed a thin-walled unilocular cyst.

This is a benign condition, best treated by surgical excision. Since these lesions are benign, during their excision the underlying vascular and neural structures of the neck are preserved.

In this particular patient, surgical exposure revealed a thin-walled unilocular cyst (Fig. 2), which was removed in its entirety (Fig. 3). There has been no evidence of recurrence, three years after the procedure.

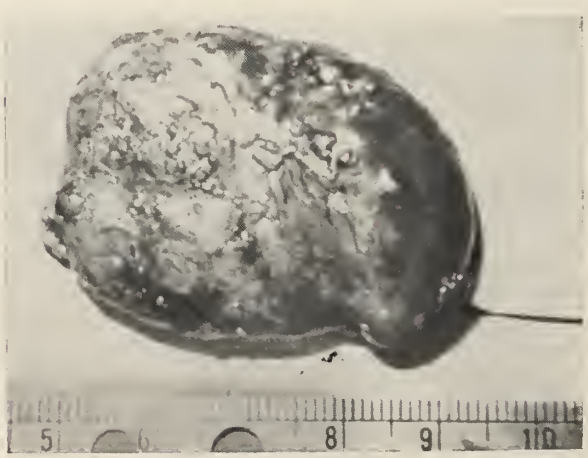


Fig. 3. Cystic lesion was removed in its entirety. Underlying vascular and neural structures were not disturbed.

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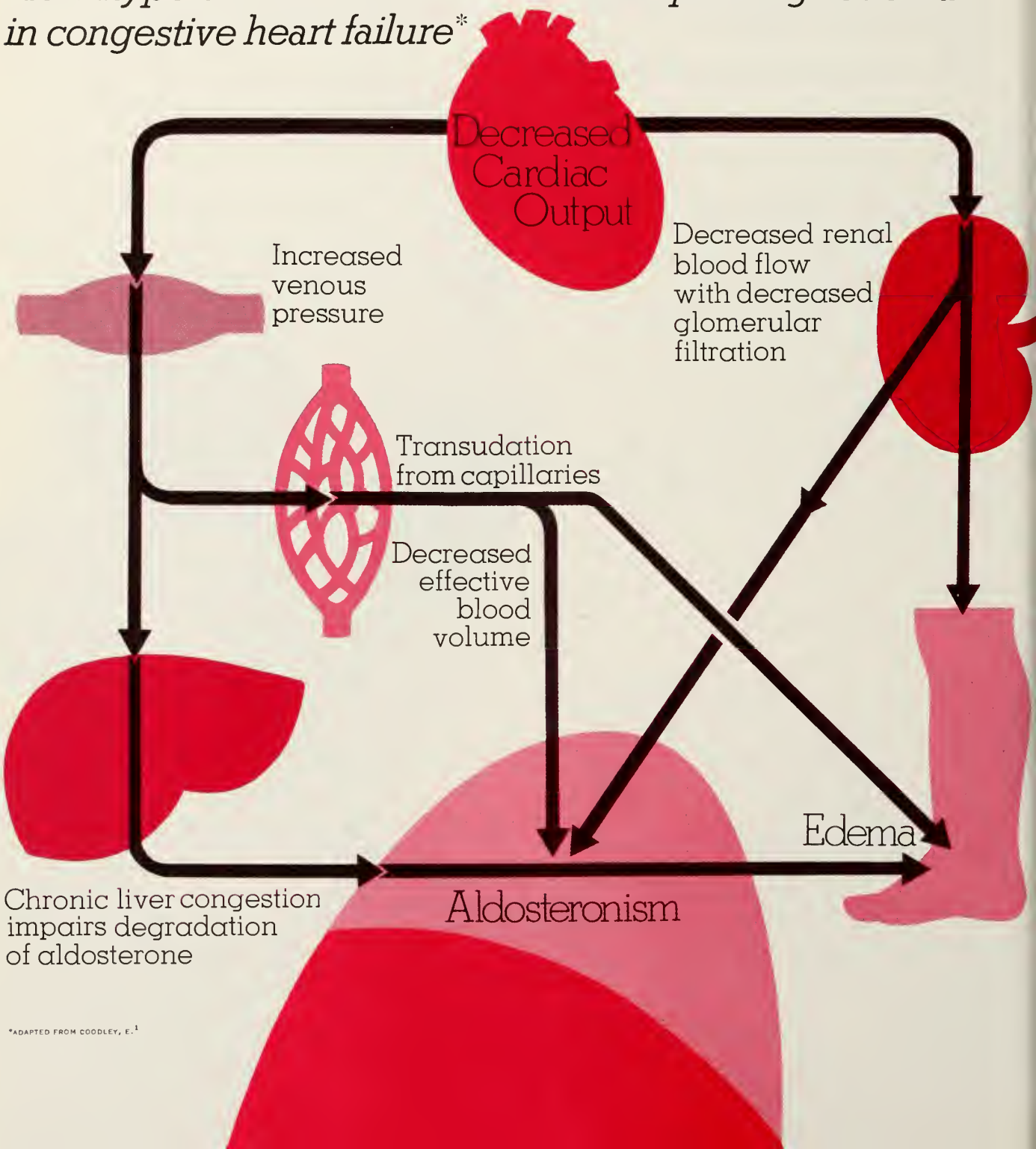
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- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension, edema or oscites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironalactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

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Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 305432

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Professional Activities



Report on AMA Clinical Convention

THE AMERICAN MEDICAL ASSOCIATION, at its Anaheim, California, Clinical Convention, reaffirmed its stand in favor of professional peer review, but took an if-we-have-to-live-with-it position regarding the PSRO program. In considering a number of resolutions and reports, the AMA House of Delegates affirmed intense efforts to obtain relief for physicians from economic controls, echoed its long stand in favor of physicians on hospital boards, set guidelines on emergency departments, and took action on a number of other policy matters.

Wording of New AMA Policy on PSRO

The new AMA Policy on Professional Standards Review Organizations (PSROs), essentially a compendium of several different policies, is embodied in the final paragraphs of Report EE, adopted by delegates to the Clinical Convention in Anaheim, Calif. The amended portion of the report reads as follows:

The AMA affirms the following principles:

1. That the medical profession remains firmly committed to the principle of peer review, under professional direction, and

2. That medical society programs of proven effectiveness should not be dismantled by PSRO implementation, and

3. That the association suggests that each hospital medical staff, working with the local medical society, continue to develop its own peer review, based upon principles of sound medical practice and documentable objective criteria, so as to certify that objective review of quality and utilization does take place; to make these review procedures sufficiently strong as to be unassailable by any outside party or parties; and that the local and state medical societies take all legal steps to resist the intrusion of any third party into the practice of medicine, and

4. That this House of Delegates, as individual physicians and through the Board of Trustees and its Council on Legislation, work to inform the public and legislators as to the potential deleterious effects of this law on the quality, confidentiality, and cost of medical care; and the hope that the Congress in their wisdom will respond by either repeal, modification, or interpretation of rules which will protect the public.

The considered opinion of the House of Delegates is that the best interests of the American people, our patients, would be served by the repeal of the present PSRO legislation. It is also believed that this is consistent with our long-standing policy and opposition to this legislation prior to passage.

The considered opinion of the Board of Trustees and the Council on Medical Service is to recommend to the House of Delegates that the AMA continue to exert its leadership, and support constructive amendments to the PSRO law, coupled with continuation of the effort to develop appropriate rules and regulations.

AMA to Continue Intense Efforts to Obtain Relief from Fee Curbs

The American Medical Association will continue its intense efforts to obtain relief for physicians from economic controls.

"All available administrative resources" will be utilized, but the effort will not—at least for the time being—include court action.

The House of Delegates rejected a number of resolutions and motions that would have mandated the filing of a lawsuit to challenge the "discrimi-

natory and unfair" regulations. It was clear, however, that the AMA Board of Trustees intends to leave the door open to possible legal action if a number of appeals now pending before the Cost of Living Council fail.

Attendance

The AMA Clinical Convention drew 7,738, including 3,179 M.D.s.

AMA Told of AHA Action to Expand M.D.'s Hospital Voice

The American Medical Association and the American Hospital Assn. are treading a delicate course in trying to reach agreement at both officer and membership levels on some touchy issues—one of the most controversial being the relationship between hospital medical staffs and hospital governing boards and administrators.

The subject of physician-hospital relations reared its head numerous times at the AMA's Annual Convention and each time fears were voiced by physicians about their possible loss of influence in hospitals and about lay control of medicine.

The most significant occurrence in Anaheim affecting physician-hospital relationships may have been an announcement from John Kauffman, board chairman of the AHA, who told a reference committee that his board recently voted to "strongly advocate" physician membership on hospital governing boards—a position which the AMA has long sought.

Emergency Department Guidelines Set

The medical profession, hospitals, and communities should work cooperatively to organize and provide prompt and efficient emergency medical care, said a report on hospital emergency department services approved by AMA's House of Delegates.

The recommendation was one of six made by a task force on hospital emergency department services, established by the Board of Trustees in January, 1972, to study problems involved in such services and to explore alternatives for providing care to non-emergency patients.

Other recommendations accepted by delegates were:

1. Physician-operated facilities providing extended hours of care should be explored as a source of emergency medical care for a community.

2. If the hospital-based facility is considered by a community as the most feasible solution, plans adopted in Alexandria, Va., and Pontiac, Mich., should be used as staffing models.

3. The medical profession should continue to direct public education toward the appropriate use of the hospital emergency department and the existence of alternative sources of medical care in the community.

4. Continuing education programs in emergency medical services for physicians should be supported and expanded.

5. Medical and allied medical organizations should continue to maintain a close surveillance on this area of medical care delivery and should seek solutions to problems presented in the overutilization and inappropriate utilization of hospital emergency departments.

Full Student Funding Sought

Twelve recommendations calling for complete and adequate financing of medical students were approved by the House of Delegates of the American Medical Association in Anaheim.

AMA to Pick New EVP in Six Months

A successor to retiring AMA Executive Vice-President E. B. Howard, M.D., is expected to be named in the next six months.

Liability Commission Backed by House

The AMA House of Delegates voted to give "highest priority" to financial and organizational support of the new Medical Liability Commission formed earlier this year to seek solutions to professional liability problems.

Abortion Policy Reaffirmed

Delegates reaffirmed the AMA's policy on abortion.

In essence, the policy requires that abortions be performed in accordance with "good medical practice"—that is, the physician must exercise sound clinical judgment, insure there is informed patient consent, and evaluate the individual's medical and emotional needs.

Specifically, the AMA statement says: "Abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and that no M.D. or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally-held moral principles. In these circumstances good medical practice requires only that the physician or other professional personnel with-

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draw from the case so long as the withdrawal is consistent with good medical practice."

Guidelines Regarding Euthanasia Are Adopted

Euthanasia often presents itself as a physician's dilemma, and doctors have been faced with numerous discussions on mercy killing and death with dignity both through the public news media and professional literature.

The problem reached the floor of the House of Delegates at the American Medical Association's Clinical meeting in Anaheim, where, after extensive debate, a Judicial Council report establishing guidelines was adopted.

About mercy killing, the guideline said:

"The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association."

On death with dignity, the guideline position was:

"The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family."

AMA-Specialty Society Ties to be Studied

The far-reaching question of the AMA's relationship with national medical specialty groups is going to get a long, hard look in the next several months.

At issue is the continuing push for direct representation of specialty societies in the AMA House of Delegates—an issue that has surfaced several times in recent years.

Change in Trustee Election Rules Voted

After being defeated several times in the past, a proposal to elect members of the AMA Board of Trustees on an at-large basis won approval of the House of Delegates.

In approving a procedure outlined in a resolution proposed by the Minnesota delegation, the House went against a reference committee report suggesting that "no new evidence" had been presented to indicate a change in the present system of electing trustees "would be beneficial to the AMA."

Traditionally, candidates for the Board have run for specific seats, rather than on an at-large basis. The current election method, however, is not mandated in the AMA bylaws.

Service on Ohio Delegation Recognized

The AMA House of Delegates by official action recognized the long and faithful service of Dr. Frederick P. Osgood, of Toledo, as a delegate from Ohio to the American Medical Association. Dr. Osgood served on the Ohio Delegation from 1962 through 1973, and was not a candidate for reelection. In addition to his service to the AMA, he has served as member or chairman on numerous OSMA committees and on a number of Reference Committees of the OSMA House of Delegates.



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President

MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals

Proceedings of The Council

Meeting of December 15-16, 1973

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday, December 15, and Sunday, December 16, 1973, at the OSMA Headquarters' office, 17 S. High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council (with the exception of Dr. Tye); John H. Budd, M.D., Cleveland, Member of the AMA Board of Trustees; Mr. James E. Pohlman, Columbus, OSMA Legal Counsel; Mr. James S. Imboden, Columbus, Assistant Director of the AMA Public Affairs Division; Richard L. Meiling, M.D., Columbus, Chairman, Ohio Delegation to the AMA; Mr. William J. Lee, Columbus, Administrator of the Ohio State Medical Board; John W. Cashman, M.D., Columbus, Ohio Director of Health, and Messrs. Page, Edgar, Campbell, Clinger, Rader, Houser, Mrs. Wisse, Mr. Moore and Mrs. Dodson, of the OSMA staff.

Those present Sunday were: All members of the Council (with the exception of Dr. Tye); Dr. Budd, Mr. Pohlman, Mr. Imboden, Messrs. Page, Edgar, Campbell, Clinger, Rader, Mrs. Wisse, Mr. Moore and Mrs. Dodson.

The President read communications from Laura Lockhart, Vice-President of the American Society of Medical Assistants.

The following resolution was adopted with regard to the death of H. P. Worstell, M.D., who served on the Council as Treasurer from 1946 to 1952:

WHEREAS, H. P. Worstell, M.D., Orthopedic Surgeon, formerly of Columbus, Ohio, and, since 1970, Long Beach, California, died November 20, 1973, and

WHEREAS, Dr. Worstell served this Association as Chairman of the Committee on Workmen's Compensation from 1947 to 1966, and

WHEREAS, Dr. Worstell served with distinction on this Council as Treasurer of the Association from 1946 to 1952, and

WHEREAS, Dr. Worstell served his country as a Medical Officer in the United States Navy, attaining the rank of Captain, therefore be it

RESOLVED, That this Council express to Mrs. Worstell and to their family, its appreciation for his service to medicine and to his country during his life and its sorrow at his death.

Minutes Approved

Minutes of the Council Meeting, November 3-4, 1973, **were approved.**

Membership and Fiscal Matters

Membership statistics were presented by Mrs. Wisse, indicating that as of November 29, 1973, there was a membership of 10,524, a gain of 195 over the preceding year. Ohio membership in the American Medical Association showed a gain of 93.

Building Committee

Minutes of the Building Committee meeting of November 4, were presented by Mrs. Wisse and **were approved.**

Auditing and Appropriations Committee

The Council convened in Executive Session and Dr. Lieber presented the minutes of the Auditing and Appropriations Committee meeting of December 14. The minutes **were approved** as presented.

Dr. Lieber presented the budget for 1974. The budget **was approved.**

The Council **adopted** a motion to pay mileage rate of 15¢ per mile for reimbursement involving motor vehicle operation on Association business.

By official action, the Council voted to submit to the 1974 Annual Meeting of the House of Delegates a resolution to increase OSMA dues. The resolution was adopted, with one negative vote (First District Councilor).

American Medical Association

Drs. Meiling and Budd reported on the Clinical Session of the AMA, Anaheim, California, December 1-5.

The Council ratified the following statement on Peer Review Systems, which was presented by

President Clarke to the House of Delegates of the American Medical Association, December 3, 1973:

"1. The Ohio State Medical Association does not support the PSRO Section of Public Law 92-603.

"2. The Ohio State Medical Association hopes this section of the law might be repealed.

"3. In the event this Law is or is not repealed, the Ohio State Medical Association has developed a computerized Peer Review Systems—controlled and operated by licensed, practicing physicians—to assure quality of care of all Ohio patients, producing data that will demonstrate the excellence of this care.

"4. In event the Secretary of the Department of Health, Education and Welfare does not accept Ohio's Peer Review Systems, then we shall pursue all avenues of recourse available to us.

"HOWEVER, in event the Secretary accepts Ohio's Peer Review Systems, then the following resolution of the 1973 House of Delegates of the Ohio State Medical Association will apply:

"RESOLVED, That if any rules or regulations promulgated by the Secretary of HEW constitute a violation of medical ethics or OSMA policy and/or cause a deterioration of the quality of care rendered to patients, then OSMA Council shall immediately recommend to its Peer Review Systems that it notify the Secretary of HEW that any provisional agreement be terminated."

Ohio Director of Health

The Ohio Director of Health, John W. Cashman, M.D., told the Council that the Hill-Burton Act provides authority for a certificate of need program in Ohio and that the Public Health Council will serve as a hearing and appeals body for the proposed program.

He announced that the Governor's Task Force on Health Care would meet on December 18, to look at recommendations from five committees constituting the Task Force.

Dr. Cashman told the Council that he wants a state-sponsored Occupational Health Program and the support of the Ohio State Medical Association on such program.

Medical Advances Institute

Dr. Henry reported on the Board of Trustees meetings of Medical Advances Institute, held November 28 and December 12, 1973.

Ohio Medical Indemnity, Inc.

Dr. Schultz reported on the Executive Committee meeting of Ohio Medical Indemnity, Inc., December 12, 1973.

Federal Legislation

The report on Federal legislation was read by Mr. Edgar. He indicated that amendments to the pension laws (Keogh) were a dead issue for 1973, but were reported to have high priority in 1974. He advised the Council that the Administration's National Health Insurance proposal would probably be presented in 1974 and that HEW Secretary Weinberger may endorse a National Formulary.

State Legislation

Mr. Rader presented the Council with various legislative proposals which will face the Association in 1974. Among these is a bill to establish a separate board for chiropractors, contraceptive advice for minors, revisions of the Medical Practice Act, the abortion bill, physician's assistants, changes in commitment procedures and bills to cope with the Medicaid problem and the malpractice problem.

The Council discussed the 1973 enactment of S.B. 209 (Jackson), to provide for prenatal tests for gonorrhea. This matter was referred to the Committee on Laboratory Medicine for a position paper. The Executive Director was instructed by the Council to notify county medical societies of this action.

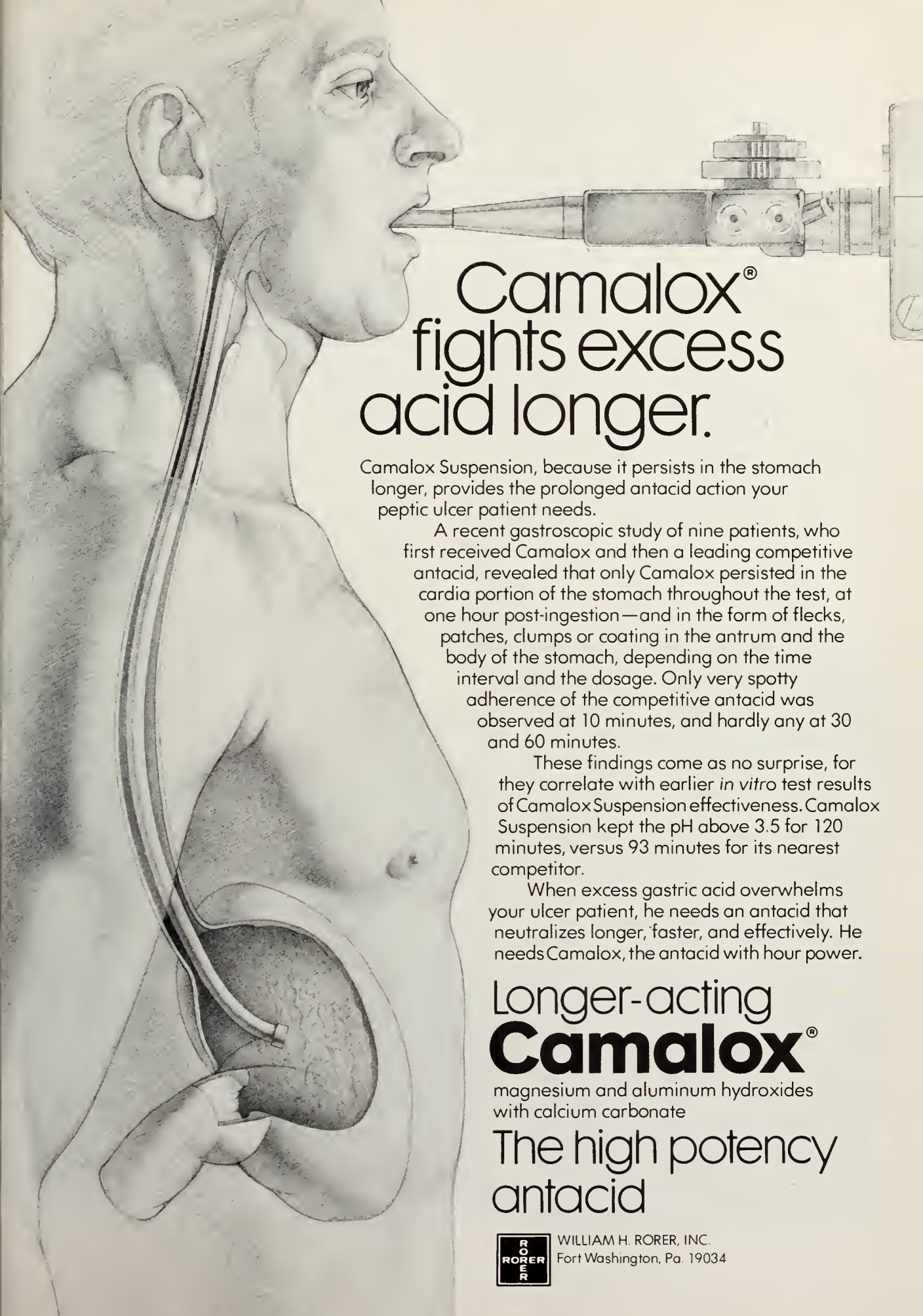
Committee Reports

Joint Advisory Committee on Sports Medicine

Minutes of the Joint Advisory Committee on Sports Medicine meeting of November 7, were presented by Mr. Clinger and **were approved.** Included in the recommendations that were approved were: a videotape on a pilot basis of an upcoming Sports Medicine Conference of the OSMA-OHSAA; a survey of all OHSAA member schools to obtain the names of team physicians for publication in the *Athlete* and *The Ohio State Medical Journal;* a survey of the team physicians as to the amount of coverage provided at each school; a sports medicine exhibit at the 1974 Annual Meeting and a special certificate to be developed by the OHSAA for team physicians who have completed at least five years service.

Ohio Foundation for Medical Care

Mr. Rader presented the minutes of the Incorporators' Meeting of the Ohio Foundation for Medical Care, November 28, 1973. The minutes were received for information. Thereupon, Mr. Rader presented the minutes of the meeting of



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the Trustees of the Ohio Foundation for Medical Care, November 28. These were received for information.

Committee on Organ Transplant

The minutes of the Committee on Organ Transplant meeting of November 26, were presented by Mr. Rader, and **were approved.**

Ad Hoc Committee on Complaint Procedures

Minutes of the Ad Hoc Committee on Complaint Procedures meeting of November 28, were presented by Mr. Campbell and **were approved.**

Council Fee Review Committee

The minutes of the Council Fee Review Committee meeting of December 14, were presented by Mr. Campbell.

The report of the Council Fee Review Committee **was approved** as amended.

Committee on Public Relations

Mr. Edgar presented a series of recommendations from the Committee on Public Relations, signed by Luther W. High, M.D., Chairman.

The Council **approved** the suggestion for improved liaison between county medical societies and hospital staffs.

With regard to communications with the membership concerning Annual Meeting resolutions submitted by the various county medical societies, it was the expression of Council that all members be notified through the *OSMAgram* and *The Ohio State Medical Journal* that packets are available from the county medical societies and the Ohio State Medical Association, upon request. These packets contain resolutions and other appropriate material.

The report, as a whole, was accepted for guidance.

Committee on Podiatry Relations

The minutes of the Committee on Podiatry Relations meeting of November 7, were presented by Mr. Rader and were accepted for information.

Ohio Health Resources Council

Dr. Clarke and Mr. Page reported to the Council on meetings of the Ohio Health Resources Council held September 12, October 3 and November 7, and it was announced that the Council has adopted a statement of purposes and objectives and that this information has been released to the public in a news conference held November 26, 1973.

Ohio State Medical Board

Mr. William J. Lee, Administrator of the Ohio State Medical Board was introduced and discussed a number of problems with the Council.

Councilor Reports

The Councilors reported on activities in their respective districts.

A written report from Dr. Tye was read by the President.

Highland County Matter

Dr. Clarke reported to the Council on the visit, by a team of representatives of the OSMA, Ohio Hospital Association and the Ohio Osteopathic Association of Physicians and Surgeons, to the Highland District Hospital, its staff and trustees on November 21, 1973. The Council reviewed copies of the ten recommendations of the team for improvement of the situation—one of the recommendations being that the Highland County Medical Society be reactivated as soon as possible.

Mr. Page presented a request from the medical staff and trustees for review of the Anesthesiology Department of the hospital. The Council referred the request to the Medical Advances Institute for implementation with instructions that billing for the cost of such review be sent to the OSMA for forwarding to the hospital.

Hospital Staff Application Forms

Dr. Clarke reported on the American Medical Association consideration of the problem of comprehensive hospital staff application forms and that John D. Porterfield, M.D., Director, Joint Commission on Accreditation of Hospitals, had reported to the American Medical Association that information resulting in the promotion of these forms was in error and Dr. Porterfield assured the Reference Committee at the American Medical Association meeting that the surveyors would be reindoctrinated in this program so that the matter would be corrected.

Investigation of Deaths

A letter was received from the American Medical Association, calling for a comprehensive study of a possible inadequacy of official medicolegal investigation of deaths. The Council asked its President to refer the matter to the appropriate committee and that such committee request consultation from Drs. Frank P. Cleveland, of Cincinnati; William A. Kolozsi, Salem, and Samuel R. Gerber, Cleveland.

Resolutions

Resolutions on Professional Standard Review Organizations from the Stark County Medical Society and the Mahoning County Medical Society were received for information.

Guidelines for Nurse Anesthetists

Guidelines for employing nurse anesthetists and anesthesiologists' assistants, which were adopted by the Ohio Society of Anesthesiologists, September 21, 1973, **were approved,** on a divided vote.

Emergency Sports Clinic

A request for a statement from the Council with regard to an emergency sports clinic, in Columbus, Ohio, was presented. The Council voted to support the concept of coverage of athletic injuries under methods developed locally and commended the doctors for fulfilling a need with regard to coverage of athletic injury problems in the area. However, the Council pointed out that it is not its policy to endorse any particular group.

AMA Membership Project

Mr. Imboden reported to the Council on AMA Membership Department plans and programs for 1974. The Council endorsed this program and referred it to the Committee on Membership and Planning.

Dayton Experiment

The Executive Director reported on a telephone call from a physician in Dayton, regarding his misgivings concerning the "Dayton Experiment." The Council requested that Dr. Tye keep it informed concerning developments and asked for a report at the next meeting in January. Presented for the Council's information was a report on the project in the November, 1973, issue of the *Montgomery County Medical Society News.*

ATTEST: Hart F. Page
Executive Director

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SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
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WARNING: Overdosage may cause muscle tremor and convulsions.
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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964

Plans Show High Points of 1974 OSMA Annual Meeting

CYCLES OF LIFE AND HEALTH has been chosen as the 1974 Ohio State Medical Association Annual Meeting theme. Practically all OSMA Scientific Sections as well as Specialty Societies will participate by sponsoring scientific programs in connection with the Annual Meeting. Dates are Sunday, May 12 through Wednesday, May 15, at the Sheraton-Cleveland Hotel, Cleveland, Ohio.

The first business session of the House of Delegates will be held on Sunday.

Monday's activities will start with a full day's program on "Vascular Disease—From Infancy to Old Age." A number of Cleveland physicians will be headline speakers in this program.

Tuesday, May 14 will be a busy day with many of the scientific sections staging programs of particular interest to their specialty groups. Among programs of special interest will be those on pathology, ophthalmology, internal medicine, neurology, rheumatology and occupational medicine. The thoracic surgeons and chest physicians will sponsor a program, and a special panel-type presentation on the Interrelationships of ENT, allergy and general practice-family practice will be held.

Wednesday, May 15 will be the last day of the meeting and will prove to be filled with educational activities. A full-day program on "Run for Your Life" will be a high point, in medical education. This program will be sponsored by the Section on Pediatrics, Section on Physical Medicine and Rehabilitation, and the Section on Sports Medicine. Representatives of these groups have put together a program of outstanding quality.

Other programs on Wednesday will be sponsored by the Section on Neurosurgery, the Ohio Psychiatric Association with the Section on Psychiatry, and the Section on Allergy with the Ohio Society of Allergy and Immunology.

Six Postgraduate Courses are offered on Tuesday and Wednesday mornings, from 7:30 to 9:00 a.m. There is a $15.00 registration fee for each course. They are as follows: Course I—Acid Base Disturbances and Blood Gases; Course II—Ischemic Heart Disease; Course III—Principles of Electrocardiography; Course IV—Concepts of Immunology; Course V—Current Concepts in Antibiotic Therapy; Course VI—Radioactive Scans and Their Applications.

Social Function: Remember the OSMA social function to be held at the Frederick C. Crawford Museum. There will be a catered dinner, bar, and a dance orchestra featuring music of the 30's and 40's. Buses will take patrons from the hotel to the Museum and return them following the dance.

Exhibits: Ohio has built a reputation for its outstanding Annual Meeting exhibits. Features will be Scientific Exhibits, Health Education Exhibits, and Technical Exhibits. The latter will be sponsored by pharmaceutical manufacturers and other suppliers of physicians' needs.

Exhibits will open on Monday, May 13 at 5:30 p.m. until 8:00 p.m. for a special showing. Tuesday and Wednesday, exhibits will be open from 9:00 a.m. to 4:30 p.m.

Art Show: This special feature of the Annual Meeting will be sponsored by the Academy of Medicine of Cleveland and the Ohio State Medical Association. Dr. Victor C. Laughlin, has been named Art Show chairman. He is president-elect of the American Physicians Art Association.

Entries in the Art Show are open to members of the OSMA, and their wives (or husbands). Those interested in exhibiting their own creations in works of art (or who wish additional information) should fill out the application form included in this issue and forward it to Dr. Laughlin.

Attention, All Medical Assistants: Last year's program for medical assistants proved so successful that planners of the Annual Meeting decided to hold a similar meeting this year. This program is on Tuesday, May 14, beginning at 2:00 p.m. Medical assistants are urged to make arrangements now with their employers to attend. They may wish to purchase tickets for the OMPAC luncheon which will be over in time for the 2:00 o'clock session.

House of Delegates: The meeting will start with the first session of the House of Delegates on Sunday, May 12. The final session will be held on Wednesday afternoon.

Registration for those attending the House of Delegates will open at 3:00 p.m. in the Sheraton-Cleveland Hotel. Councilor District Caucus meetings will be held in hotel suites assigned to Councilors.

A buffet dinner for those attending the House of Delegates in an official capacity will be served at 5:30 p.m. in the hotel. The business session will get underway at 7:00 p.m.

Reference Committee hearings will start at 8:30 a.m. on Monday, May 13 in rooms designated in the program. Hearings will continue on Monday afternoon.

Must vasodilators and therapy for other diseases come into conflict?



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VASODILAN®
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the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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1974 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1974 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Sheraton-Cleveland Hotel, 24 Public Square, Cleveland, Ohio. Exhibit Days and Times will be as follows: Monday, May 13 — 5:30 P.M. - 8:00 P.M.; Tuesday, May 14 — 9:00 A.M. - 4:30 P.M. and Wednesday, May 15 — 9:00 A.M. - 4:30 P.M.

Mail applications to the attention of J. E. Tetirick, M.D., Chairman, Committee on Scientific Work, Ohio State Medical Association, 17 South High Street, Suite 500 Columbus, Ohio 43215.

APPLICATION FOR SPACE
SCIENTIFIC EXHIBITS

1974 Annual Meeting, Ohio State Medical Association

Sheraton-Cleveland Hotel, Cleveland, May 13, 14 and 15

___I am interested in receiving an application and details regarding space for a scientific exhibit at the 1974 OSMA Annual Meeting. Please send to:

Name_____

City_____ State_____

Art Show Planned

FOR 1974 OSMA ANNUAL MEETING

Space will be provided at the 1974 Annual Meeting of the Ohio State Medical Association, Monday, May 12th through Wednesday, May 15th for a Physicians' Art Show. The Art Committee of the Academy of Medicine of Cleveland will merge their efforts with those of the Committee on Scientific Work of the Ohio State Medical Association, for the creation of a magnificent Art Show at the annual meeting.

Members of the OSMA, their wives (or husbands), who are interested in exhibiting pieces of art work (they personally have created) or who require information concerning the exhibit, should fill out the application included below *without delay.*

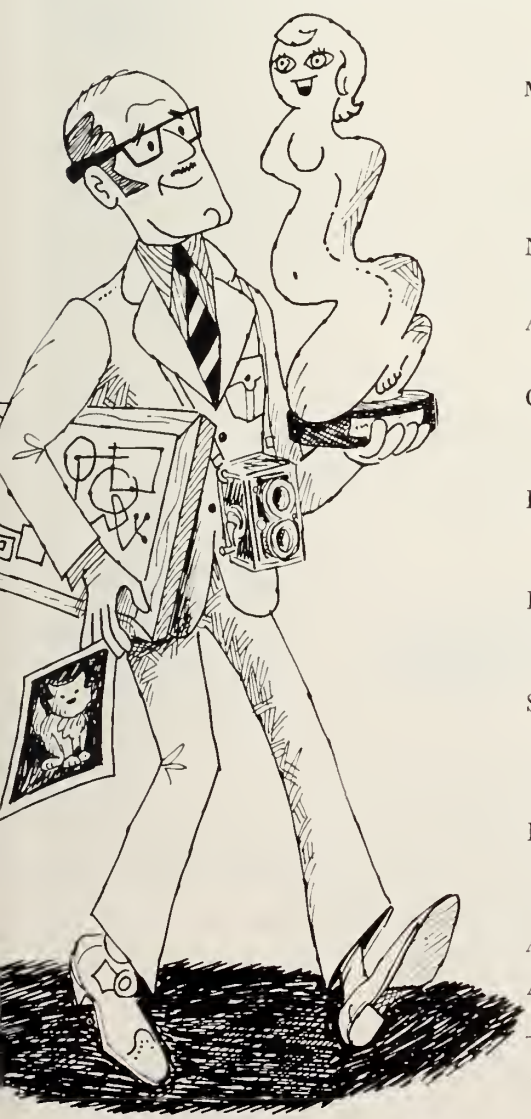
It will be the responsibility of each exhibitor to see that his work gets to the exhibit area, on the balcony of the Exhibit Hall, in the Sheraton-Cleveland Hotel, NO SHIPMENTS WILL BE ACCEPTED. Time to receive such deliveries: Monday, May 13th from 8:00 a.m. to 4:00 p.m. (the earlier the better). No exhibits can be accepted after 4:00 p.m. on Monday, 13th (except by very special arrangements).

Each exhibitor will be responsible for transportation costs, insurance and other expenses involved in entering his or her exhibit. Guards will be provided for protection.

Exhibitors will be limited to two art pieces per category. Categories will be (1) Paintings (watercolor); (2) Paintings (oil) and (acrylics); (3) Sculpture; (4) Photo-Arts; and (5) Crafts.

An independent Art Award Committee will judge the exhibit competitively—ribbons will be awarded.

We solicit your exhibits and hope you will assist us to make the 1974 Art Show an outstanding success.



Application for Space in 1974 OSMA Art Show Exhibit

Mail to: **Victor C. Laughlin, M.D., Chairman**
1974 OSMA Art Show Committee
Academy of Medicine of Cleveland
10525 Carnegie Avenue
Cleveland, Ohio 44106

Name_____

Address_____

City_____ Zip Code_____

		Title	Dimensions	Value*
Paintings (watercolor)	1.			
	2.			
Paintings (oil & acrylics)	1.			
	2.			
Sculpture (pedestal— or wall type—	1.			
	2.			
Photo-Arts (mounted, ready to hang)	1.			
	2.			

Additional information desired or which you believe will be helpful to the Art Show Committee. _____

_____

_____

(*Please include a fair market value for insurance)

Obituaries

Edgar Campbell Baker, M.D., Youngstown; Western Reserve University School of Medicine, 1921; aged 78; died December 22; member of OSMA, AMA, American Thoracic Society, American Roentgen Ray Society, Radiological Society of North America, and American Radium Society; Fellow, American College of Radiology; diplomate, American Board of Radiology; practitioner in Youngstown beginning in 1934 and long associated with Youngstown Hospital Association; past president of the Ohio State Radiological Society.

John U. Buchanan, Jr., M.D., Clearwater, Fla.; University of Pennsylvania School of Medicine, 1911; aged 89; died December 6; member of OSMA, AMA, and Aerospace Medical Association; practitioner of long standing in Youngstown, and resident of Florida since 1954; veteran of World War I.

Charles A. Chesner, M.D., Lorain; University of Edinburgh Faculty of Medicine, 1937; aged 61; died December 10; member of OSMA, AMA, International Academy of Pathology, American Society of Clinical Pathologists and American Society of Cytology; Fellow, College of American Pathologists; diplomate, American Board of Pathology; practitioner in Lorain since 1946 and long associated with St. Joseph Hospital there; deputy coroner for Lorain County.

Stuart Peyton Cromer, M.D., Columbus; Northwestern University Medical School, 1935; aged 80; died December 13; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner of long standing in Columbus and member of the Upper Arlington Board of Health. Among physician members of the family who survive are his son, Dr. David W. Cromer, of Evanston, Ill., and a brother, Dr. Horrace E. Cromer, of Austin, Texas.

Harold Orris Crosby, M.D., Findlay; University of Cincinnati College of Medicine, 1928; aged 71; died November 24; member of OSMA and AMA; native of Findlay and practitioner there for virtually all of his professional career; Hancock County coroner from 1928 to 1942; veteran of World War II.

Benjamin Conrad Diefenbach, M.D., Columbus; Western Reserve University School of Medicine, 1937; aged 62; died December 15; former member of OSMA; practitioner in the Martins Ferry area until 1966; since 1966 associated with the Ohio Industrial Commission with offices in

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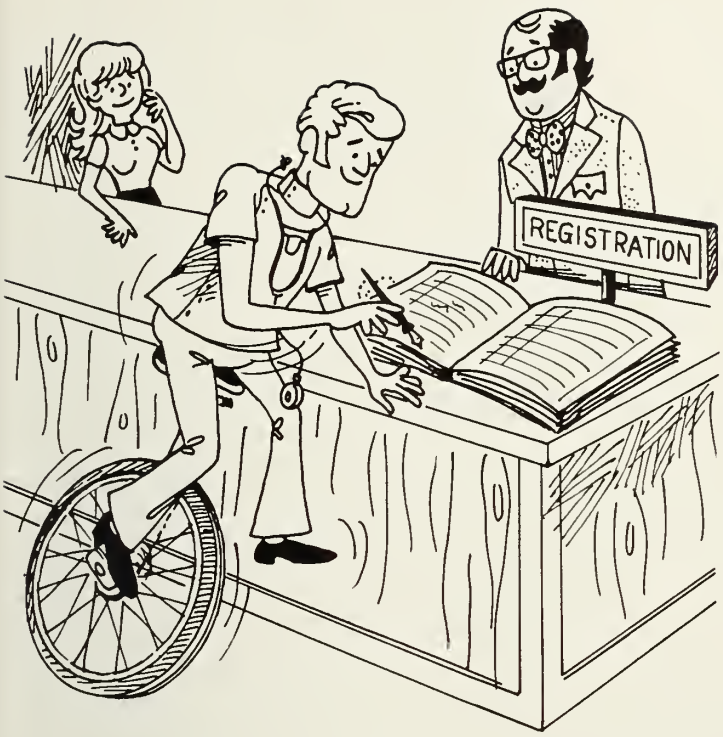
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Organization_____

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(If other occupants in room, give names)

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Price Range _____ Other Accommodations _____

Guaranteed _____

ARRIVAL DATE: May_____ at _____ A.M. _____ P.M.

DEPARTURE DATE: May_____ at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION

Columbus; member of The Council of the Ohio State Medical Association from 1960 to 1966 as Councilor of the Seventh District; past president of the Belmont County Medical Society and active in numerous Society functions.

William Tarvin Fenker, M.D., Sandusky; Ohio State University College of Medicine, 1914; aged 84; died December 17; member of OSMA and AMA; practicing physician and surgeon in the Sandusky area for 56 years; veteran of World War I.

Joseph Charles Forrester, M.D., Columbus; Ohio State University College of Medicine, 1940; aged 60; died December 5; member of OSMA, AMA, and American Academy of Family Physicians; practitioner for many years in Columbus and physician for the Student Health Service at OSU; member of the Columbus Board of Health for 12 years, and past president of the Board; past president of the Central Ohio Academy of Family Physicians; veteran of World War II.

Eric Boyd Howell, M.D., Chagrin Falls and Cleveland; Dalhousie University Faculty of Medicine, 1940; aged 56; died December 9; member of OSMA, AMA, and American Society of Anesthesiologists; practitioner in the Cleveland area since 1950, specializing in anesthesiology.

Edward W. Keefer, M.D., Springfield; New York Medical College, 1937; aged 64; died December 3; member of OSMA and AMA; general practitioner in the Springfield area since 1937.

Ira Mortimer Levy, M.D., Cleveland; University of Texas Medical Branch, Galveston, 1953; aged 47; died November 27; member of OSMA, AMA, American Society of Anesthesiologists, and International Anesthesia Research Society; practitioner in Cleveland for a number of years, specializing in anesthesiology; from 1954 to 1956 served with the U. S. Air Force.

David Magid, M.D., Cleveland; Ohio State University College of Medicine, 1928; aged 76; died December 9; former member of OSMA and AMA; Fellow, American College of Radiology; diplomate, American Board of Radiology; practitioner in Cleveland for virtually all of his professional career and in recent years associated with the Veterans Administration; veteran of World War II.

E. Richard Marker, Jr., M.D., Toledo; Ohio State University College of Medicine, 1952; aged 51; died December 16; member of OSMA and the American Academy of Family Physicians; former member of AMA; practitioner in Toledo for about 17 years; retired some three years ago for health reasons. His father, the late E. Richard Marker, Sr., also practiced in Toledo.

George Eli Moats, M.D., Fort Wayne, Ind.; Eclectic Medical College, Cincinnati, 1913; aged 87; died December 10; practiced many years ago in Paulding, Ohio, but most of his practice was in the Fort Wayne area.

I. Darin Puppel, M.D., Columbus; Ohio State University College of Medicine, 1936; aged 64; died December 17; member of OSMA, AMA, American Geriatrics Society and the Central Society for Clinical Research; Fellow, American College of Surgeons; diplomate, American Board of Surgery; practicing surgeon of long standing in Columbus and former professor in the Department of Surgery at OSU College of Medicine. Dr. Allen E. Puppel, also of Columbus, is a brother.

Arthur Williams Robishaw, M.D., Elyria; Western Reserve University School of Medicine, 1927; aged 70; died December 7; member of OSMA, AMA, and Central Association of Obstetricians and Gynecologists; Fellow, American College of Obstetricians and Gynecologists and the American College of Surgeons; diplomate, American Board of Obstetricians and Gynecologists; practicing physician and surgeon in Elyria since 1934; served as a medical officer in the U. S. Navy during World War II.

Hudson Frederick Ross, M.D., Lorain; Ohio State University College of Medicine, 1922; aged 77; died December 17; former member of OSMA; retired in recent years after long practice in Lorain; former city physician; veteran of World War II.

Curtis Sylvester Stitts, M.D., Troy; University of Cincinnati College of Medicine, 1942; aged 56; died December 4; resident of Troy for about eight years; associated with the Veterans Administration Hospital in Dayton.

John R. Willoughby, Sr., M.D., Warren; Ohio State University College of Medicine, 1912; aged 89; died December 2; member of OSMA and AMA; retired in recent years after long practice, first in Orwell and from 1918 in Warren. Among survivors is his son Dr. Robert J. Willoughby, also of Warren.

Letter of Protest

The Ohio State Medical Association is registering a strong protest against proposed regulations published in the Federal Register regarding preadmission review regulations covering Medicare and Medicaid patients. Following is President Oscar W. Clarke's letter of protest to the Secretary of HEW with the official approval of The Council.

Dr. Clarke is calling upon every member of the Association to voice opposition through whatever means are available. Particularly, he is asking each member of the Association to back this protest by not participating in the proposed program.

Ohio State Medical Association

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ELYR

January 23, 1974

Caspar W. Weinberger, Secretary
U.S. Department of Health, Education and Welfare
320 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Secretary:

This is to inform you officially that the Ohio State Medical Association has no recourse but to advise its members not to participate in any manner in implementation or operation of the regulations published in the Federal Register of January 9 which propose pre-admission review regulations for both Title XVIII and Title XIX.

The regulations proposed are repulsive to good medical care and contravene the patient's rights to health care. Further, they libel the medical profession and they would force any physician complying therewith to violate his Hippocratic Oath and the Principles of Medical Ethics.

The proposed regulations are a patent and hollow attempt to force on the medical profession and the intended patient beneficiaries of Title XVIII and Title XIX artificial fiscal controls. It is the mission and the responsibility of the physician as well as his ethical, legal and moral obligation to treat the patient to the best of his professional abilities. He does not have the time to be a paper-shuffler.

The Ohio State Medical Association forcefully opposes any attempted third party intrusion into the doctor-patient relationship or any interference into the right of the patient to that course of treatment which his personal physician prescribes for him.

The Ohio State Medical Association opposes any such third party interference, regardless of whether it comes from a governmental or non-governmental effort.

It is shocking to the medical profession to learn that the Federal government would consider such tactics, let alone actually attempt to implement them.

Since the enactment of Medicare and Medicaid legislation, it has been the official position of this Association that physicians should cooperate in all ethical and legal means possible in the implementation of those programs, in a manner that serves the best interests of their patients.

However, it must be emphasized that such cooperation cannot be possible in circumstances that violate the patient's rights and compromise the legal and ethical responsibilities of his physician.

The graduation of a physician from an accredited medical school, his subsequent licensure to practice medicine, and his demonstration of training and judgment through meeting hospital medical staff standards of competency and proficiency of judgment are substantial proof of the physician's ability and integrity.

The patent effort of the Federal government to intrude itself into this area, therefore, leaves this Association with no alternative but to urge its members to:

1. Continue to care for their patients, even as before, to their best professional ability, and

2. To exercise their individual rights to refuse to lend their professional and ethical stature to this insidious and probably unlawful program.

It is most regretable, Mr. Secretary, that medicine's continuing and wholehearted efforts to cooperate with Medicare and Medicaid officialdom always have been repulsed and, in recent months, even more viciously repulsed by our national government.

In every effort medicine has made in the past to cooperate with government programs, to offer suggestions for improving their efficiency, their outreach and their results, medicine has been rebuffed by a psychopathic wave of ridicule, insolent diatribes and slanderous retorts on the part of government officials.

The January 9 Federal Register publications represent a new low in this unceasing Federal campaign against a dedicated and honorable profession. It is painfully apparent that your Department has absolutely no interest or intent in retaining the cooperation of the medical profession.

Unless these proposed regulations are rescinded, I must reiterate the statement that this Association has no alternative but to recommend to its members that they continue to care for their patients to the best of their abilities but that they exercise their individual rights to adamantly refuse to lend their professional stature to an unethical and repulsive program.

Further, the Ohio State Medical Association strongly emphasizes that this position is not to be construed as a "strike" against our patients. To the contrary, it is the only position we can take in this instance to protect the best interests of our patients and to guarantee them ethical, moral and effective medical care.

The pre-admission certification program as advocated has been studied in Ohio for more than a year. It is obvious from these studies that it will excessively increase the work load of the busy practitioner. It is a system that will, therefore, increase the cost of medical care by increasing physician expense as well as other provider expense.

Studies indicate that the number of admissions in Ohio affected by this will be extremely low in comparison to the dollar savings. The economic waste of the proposed program and the over-all antagonism it will generate among physicians make this an inappropriate program.

Sincerely,

Oscar W. Clarke, M.D.

Oscar W. Clarke, M.D.,
President,
Ohio State Medical Association

OWC/dc

VA Reports Figures on Health Care of Veterans for Year

Admissions to Veterans Administration hospitals passed the million mark for the first time in the history of the VA during fiscal year 1973.

VA reported the 1973 total is 1,007,228—985,351 in the 170 VA hospitals and 21,877 as VA patients in non-VA hospitals. Of the one million admissions, 132,222 were for Vietnam Era veterans.

Outpatient, dental, and nursing home care for veterans also are at record levels.

During fiscal 1973, veterans made 9,165,094 visits to VA facilities for outpatient medical treatment and 1,693,397 visits to private physicians for care at VA expense. In addition, 248,388 veterans received dental treatment from VA—165,472 from private dentists under the VA hometown program and 82,916 from VA dentists.

The agency also cared for 16,287 veterans in community nursing homes, 9,535 in the VA nursing homes, and 22,094 in the VA domiciliaries.

Part of the cost of care of 12,699 veterans in the state home domiciliaries, 7,155 in the state home hospitals, and 6,967 in the state home nursing homes was borne by VA.

Of the 985,351 patients treated in FY 1973 in VA hospitals, 174,418 were psychiatric and 810,933 were medical and surgical including 7,981 with tuberculosis.

The average daily number of tuberculosis patients in the VA hospitals is the lowest in history—1,408 out of an average daily patient census of from 82,000 to 84,000. This figure for TB can be compared with 1,750 in 1972 and 15,645 in 1952.

Almost half of the VA hospitals' daily census of psychiatric patients (currently 27,034) is now on the psychiatric wards of general medical hospitals—15,866 in the 33 VA psychiatric hospitals and 12,168 in the medical hospitals.

The agency's hospitals placed 11,837 patients into community care homes (exclusive of nursing homes) in fiscal 1973.

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MDs in the News

Eighteen community and University members have accepted positions on a new Advisory Committee to the Vice-President and Director of the University of Cincinnati Medical Center.

The first meeting of the committee with Dr. Edward A. Gall, who directs the Medical Center, was held late in 1973. As recommended by UC's Board of Directors, which established the committee, the purpose "shall be to consider issues and problems that arise in community health care, especially as they relate to Cincinnati General Hospital. It shall make recommendations on such matters to the Vice President, who shall direct these into proper channels."

Physicians on the Committee are Dr. David Van Ginkel, chairman of the Cincinnati Board of Health; Dr. Edmund C. Casey, practicing physician and a representative at large; Dr. Eugene J. Burns, representing the Academy of Medicine and its president; Dr. Edward T. Buford, representing the Academy and ambulatory patient care.

Physicians meeting ex-officio with the committee will be Dr. Robert S. Daniels, interim dean, College of Medicine, and Dr. Gall.

* * *

Dr. Stanley Burton Troup, Physician-in-Chief of the Rochester, N.Y., General Hospital and Professor of Medicine at the University of Rochester, has been appointed Director of the University of Cincinnati Medical Center and a Vice-President of the University.

Dr. Troup, whose appointment is effective July 1, 1974, will succeed Dr. Edward A. Gall, who announced earlier his intention to retire from his present position in mid-1974.

Dr. Troup will have executive leadership and supervision over the Medical Center which includes Cincinnati General Hospital, the Christian R. Holmes Hospital and the Colleges of Medicine, Nursing and Health, and Pharmacy.

* * *

Dr. Robert E. Tschantz, Canton, was one of two local citizens honored at the 58th annual meeting of the Greater Canton Chamber of Commerce held late in 1973. Two awards are given each year to individuals who have made significant contributions to advancement of the community.

Dr. Tschantz received the 1973 Award of Appreciation, an inscribed plaque given to a person whose efforts within his own profession have resulted in betterment of the community. He was cited in particular as the man most responsible for establishment of Northeastern Ohio University's College of Medicine. Dr. Tschantz started campaigning for the school in 1963 and in 1967 was appointed chairman of a committee of doctors working toward the realization of the college. The school was created by a recent bill of the Ohio General Assembly.

* * *

The Ohio State University Board of Trustees in December approved the appointment of Dr. Thomas G. Skillman to the university's new endowed Chair of Endocrinology, effective January 1.

The first person named to the chair, established in September, Dr. Skillman is professor of medicine and director of the division of endocrinology and metabolism in the College of Medicine and is nationally known in this field.

The faculty position was established to provide for the teaching of endocrinology as well as for enhancing research, and for clinical learning experiences in that field. The chair is supported by income from a trust fund set up by an anonymous donor.

Medical-Science Historians to Meet in Columbus

The Ohio Academy of Medical History will join with the Ohio Academy of Science in an annual History of Science Meeting on March 16 in the OSU Medical Administration Center, 370 West Ninth Avenue, Columbus.

Principal feature of the program will be a symposium on "Medical Botany During the First Half of the Nineteenth Century in the Eastern United States." Panel members will be: For the New England Area, George E. Gifford, Jr., M.D., Watertown, Mass.; for the Philadelphia Area, Dorothy I. Lansing, M.D., Paoli, Pa.; and for the Ohio Valley, Eugene H. Conner, M.D., Louisville, Ky., and Ronald L. Stucky, Ph.D., Columbus.

Reservations should be made with Ronald L. Stuckey, Ph.D., Department of Botany, Ohio State University, 1735 Neil Ave., Columbus 43210. Emanuel D. Rudolph, at the same address, is secretary-treasurer of the Ohio Academy of Medical History.

Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

I BELIEVE IT WAS Shelley who wrote "if Winter comes, can Spring be far behind?" It's a bit early for mention of Spring in this February column; yet it really isn't all that early for mention of the State Convention to be held in Cleveland this coming May. I suppose I'm particularly aware of convention this year because I'm involved with the county report presentation and we're hoping for A County "Special" with touches of TV. . . .

Plans are yet to be finalized, but one thing is sure: the county reports' presentation will be given top billing, and a new "angle." It's nothing short of an inspiration each year to listen to the outstanding auxiliary activities at the grass roots level.

And so, now that winter's here, spring can't be that far behind, and neither can the deadline for those reports to be sent to me! (county presidents, check your workbooks. . . .)

"Direct Line"

This is the very excellent "Leader's Digest" pubished four times a year by the National Auxiliary. The most recent issue tells of two new Package Programs that have been prepared and are ready for county auxiliary use. FOCUS ON KIDS combines two programs which are priorities for 1973-74: GEMS (Good Emergency Mother Substitutes) and the Block Mother Plan. Both programs have updated materials containing new ideas and information.

Since its beginning in 1956, GEMS has become a valuable program to the auxiliary. The training of baby-sitters is an important project and one that need not be limited to teenagers. Many senior citizens can be restored to productivity and social involvement through this medium. The program has the added asset of adaptability to any size auxiliary.

The Block Mother Plan was designed to provide a haven for children going to and from school and in emergency situations. In addition to being a sound safety measure, there is the psychological advantage of providing a sense of security for children. The auxiliary's efforts in the program may be reflected in the future of many youngsters.

The new second package program is the BLOOD DONOR PACKAGE PROGRAM which has been completely revised this year with how-to material for use in establishing a blood center or in working with an existing facility. The need for human blood is constant and universal and the practice of using blood from volunteer donors only is rapidly spreading across the country. There are numerous volunteer services which auxiliary members may perform in this totally necessary life-saving activity.

Both package programs are available on request from the National Auxiliary, 535 N. Dearborn Street, Chicago, Illinois 60610 (free of charge).

For more information about GEMS and the Block Mother program, write to Mrs. Frank J. Jones, national health services chairman, 4444 Claycut Road, Baton Rouge, La. 70806; or to Mrs. Leroy J. Sides, vice-chairman, GEMS and Block Mother, 2550 S. Fairfax Place, Denver, Colorado 80222. For additional help with the blood donor program, write to Mrs. Jones or to Mrs. Robert W. Coon, vice-chairman, blood donor program, 453 S. Willard Street, Burlington, Vt. 05401.

WA-SAMA

WA-SAMA (Woman's Auxiliary to the Student American Medical Association) needs our help and here are some ways to give it, according to Mrs. Max E. Olsen, national liaison chairman:

Make WA-SAMA members feel welcome in the medical family and community by showing interest in their programs and projects. Make your home available for a meeting. Present educational programs for their members. Invite them to auxiliary meetings. Participate in their fund-raising projects. Give them moral support. Assist them financially by becoming a sustaining member (for just five dollars, the sustaining membership fee, you will receive their magazine, *Spectrum,* through which you will be aware of the progress of their programs and their budget necessities.) They are informed, interested and enthusiastic women and they need our help. (Even though it's February, it's not too late for making WA-SAMA support a New Year's resolution!)

Membership

"All advertising is local," reads the slogan of the Scripps-Howard newspapers, and it very well

could be the slogan of the auxiliary's county membership program (after all, auxiliary action begins with the county!)

Mrs. Erle E. Wilkinson, national membership chairman, suggests that auxiliaries set up a membership profile—noting potential members, delinquent members, dropouts and present members. She further suggests assigning committee members to work on specific categories and to prevail on other auxiliary members to court the potential and dropout members by inviting them as guests to meetings or to coffee in their homes. The treasurer should have assistance with early follow-up of delinquent dues. The president and the program chairman should have help in planning an orientation meeting for new—and other—members. Every auxiliary member should let her enthusiasm and ideas sell the auxiliary to other physicians' wives.

Around the State

The lovely, traditional Chrysanthemum Ball of the **Cuyahoga County** auxiliary celebrated its twentieth such gala occasion in November at the Cleveland Athletic Club. The Ball is for the benefit of the group's Philanthropy Fund and is a major source of income. Cocktails were at 6:00 p.m., followed by a 7:30 p.m. dinner. Hal Lynn's Orchestra provided the music for dancing.

The Committee for the event included: Mrs. Robert C. Kirk, chairman; Mrs. David M. Bell, Mrs. Milton E. Bobey, Mrs. Frank A. Catalano, Mrs. Nicholas Economo, Mrs. R. H. McDonald, Mrs. William Mourad, Mrs. Constantine A. Papas, Mrs. Robert H. Perchan, Mrs. Robert S. Rosner, Mrs. Paul J. Schildt, Mrs. John E. Walkowiak and Mrs. Homer T. Yoder.

On December 6, the Cuyahoga group held a Christmas party for the families of foreign doctors at the Academy of Medicine. January 25 featured a "Private Morning at Severance Hall"—an 11:00 a.m. "petite luncheon." And in February, three "estate planning" talks by John Guerra, administrative and Trust Officer of the Central National Bank, were held at the Academy of Medicine.

More in the State

Under the direction of Mrs. Charles Everett, program chairman, the **Erie County** auxiliary held an educational meeting a few months ago on child abuse and neglect. Mrs. Everett discussed recent legislation (Ohio law now permits the reporting of suspected abuse without fear of prosecution).

Marian Johnson, director of Erie County Children's Services, emphasized that child abuse is a mental health problem. Mistreatment of children, she said, is a problem which involves the cooperation of the entire community. A film titled "The War of Eggs" was shown (this film is from the library of the Ohio Department of Welfare). It gives insight into parents' backgrounds as a cause for battering children. It also makes the point that a battered child does not necessarily come from a financially poor home.

Mrs. Everett informed auxiliary members that materials for communities are now available from the National Center for the Prevention and Treatment of Child Abuse in Denver, Colorado. The "Child Abuse/Neglect Prevention Kit" prepared by the Children's Protective Services of the Ohio Department of Public Welfare was distributed among the membership.

Here and There

Members of the **Franklin County** auxiliary were in charge of the attractive table decorations for the annual Christmas dinner-dance of the Columbus Academy of Medicine. Mrs. Brooks Hurd served as chairman, assisted by Mrs. Donald Lewis, Mrs. Charles Rossel, Mrs. Ronald Mezger and Mrs. Ralph Norris.

An interesting appeal from "Jottings," the group's monthly newsletter: "How about offering

Medical Department Manager

We are looking for a qualified physician with experience in occupational medicine to assume total responsibility for the medical program at our Hamilton, Ohio, paper manufacturing facility. Scope of responsibility also involves development of programs and policies in occupational medicine including administrative, preventive and curative medicine; supervision of medical aspects of environmental hazards; as well as industrially related treatment in a well equipped clinic with appropriate staff. Regular hours. Please send curriculum vitae and salary requirements in confidence to **John B. Matz, Regional Manager-Executive Recruiting.**

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a half-hour of your time to a group of fascinating guys—those DOCTORS ON CALL! Offer your services to answer the telephone for the program presented each Sunday from 12 noon to 12:30 p.m. Call Elaine Heilman and give her your name. . . ."

The **Montgomery County** auxiliary has a provocative page in its County Medical Society's "Medical News" headed "Happiness Is". . . . A recent issue said "we want to look back to seven challenges offered to all auxiliaries from the OSMA (posed by Dr. Oscar W. Clarke, president), and that we consider "Happiness Is":

(1) Help us improve our profile (Dr. Clarke prefers to use profile rather than image which is often nothing more than an empty image in a mirror); (2) to continue and expand the activities of the Speakers' Bureau initiated last year; (3) to keep sending letters to legislators as a part of the LEGS program whenever a medically-oriented bill is introduced or a problem needs airing with medicine's point of view; (4) to read "The Case for American Medicine" by Harry Schwartz so that we can speak out about the true facts of medical care in our country; (5) to continue to educate our youth and the community with special emphasis on drug abuse, venereal disease and alcoholism in youth; (6) to keep up the good work in community service as volunteers in Red Cross, hospitals, schools, etc., (7) and this direct quote from Dr. Clarke: "OSMA challenges you to be your doctor's critic at home. He may not like it but you are in a good position to hear things being said in the community and relate them to him."

Something New

The **Stark County** auxiliary is participating in what is called a "traffic hazard elimination program." Each member has been given a mimeographed form to keep in her car and fill out when she witnesses a traffic hazard. Such information as the date, the time observed, the exact location (including a diagram and "specifics" on a separate sheet if necessary) detailed description of the hazard, the name, address and telephone of the member "reporting." The filled-out form is then to be sent to Mrs. Robert Miller, safety chairman. Sounds like a terrific idea!

Stark's January Board meeting was held at the home of Ginni Herbst. . . . Saturday, February 23, is the group's "Party Night" at the Shady Hollow Country Club. . . . A recent issue of "News Capsule," the monthly newsletter, featured "International Health" and detailed some very fine data relating to that wonderful program.

Help Wanted!

I'm afraid I'm beginning to sound like a broken record, but I **must** have your help, county auxiliaries, if this column isn't to become a victim of malnutrition. . . . Know what I mean? Let my Valentine be your news clippings and newsletters and anything else you'd like to send!

Deadline for Submission of Resolutions to OSMA Office is March 13

Delegates to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1974 Annual Meeting should be guided by Chapter 4, Section 8 of the OSMA Bylaws entitled "Resolutions."

"Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least sixty (60) days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates."

Table of Contents

Professional Activities and Other Features

(Continued From Page 70)

Page

83 New Members of the Association

88 How to Prepare for an Investigation by the Drug Enforcement Administration

90 Keeping Up: Continuing Education Opportunities for Physicians in Ohio

128 Scientific Exhibits Wanted for 1974 OSMA Annual Meeting

129 Art Show Planned for Annual Meeting

130 Obituaries

131 Make Your Hotel Reservations Now for 1974 OSMA Annual Meeting

133 Veterans Administration Reports Data on Health Care of Veterans

134 MDs in the News

134 Medical-Science Historians to Meet

135 Woman's Auxiliary Highlights

137 Deadline for Submission of Resolutions to OSMA Office is March 13

138 The Journal's Advertisers in This Issue

139 Classified Advertisements

JOURNAL ADVERTISERS

Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products and let them know that you see their advertising in *The Journal*.

In This Issue:

Abbott Laboratories 116

Allergy Laboratories of Ohio 133

The Brown Pharmaceutical Co., Inc. 76, 86, 125

Burroughs Wellcome Co. 89

Champion International 136

Dorsey Laboratories, Div. of Sandoz-Wander, Inc. 119

Flint Laboratories, Div. of Travenol Lab., Inc. 91-92, 82

Immke Circle Leasing 130

Lilly, Eli and Company 94

McNeil Laboratories 87

Mead Johnson Laboratories 127

The Medical Protective Co. 86

Pharmaceutical Manufacturers Association 80-81

Robins, A. H., Company 77-78-79

Roche Laboratories, Div. of Hoffman-LaRoche, Inc. .....Inside Front Cover-69, Inside Back Cover, and Back Cover

Wm. H. Rorer, Inc. 123

Searle Laboratories, Division of G. D. Searle & Co. 114-115

SK&F Co., Subsidiary of Smith, Kline & French Laboratories 113

Turner & Shepard, Inc. 71

The Upjohn Company 84-85

Wendt-Bristol Co. 83

Windsor Hospital 120

Wolman Insurance Agency, Inc. 88

Classified Advertisements

Rates: $1.00 per line. Minimum charge $2.00 for each insertion. Display classified, $2.00 per line. (9 lines to the inch) Prices cover the cost of remailing answers. Forms close the 8th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

Box (insert number), c/o The Ohio State Medical Journal
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

Notice of Change in Rates for Classified Advertisements

Because of increasing production costs, The Journal's Publication Committee has found it necessary to increase the rates for classified advertisements. The regular charge for classified advertisements beginning January 1, 1974 is $1.00 per line as set in type.

The rate for Display Classified Advertisements (ads other than those set in regular light face type, or boxed ads) is $2.00 per line.

All classified ads placed with The Journal office before this announcement was published will be carried at the old rate until completion of the commitment period.

PHYSICIAN'S OFFICE FOR RENT in Mariemont, a Village adjacent to Cincinnati, near a good hospital. Contact L. Hermanies, 3900 Oak St., Mariemont, Ohio. Phone 271-0291.

FOR RENT OR LEASE — General Practitioners Office for 10 years. Suite of 4 rooms—central airconditioned—carpeted—paneled. Parking in rear. Phone: 614/224-6972 or 614/231-1987.

OHIO MED. LIC. Prerequisite to qualify for full or part-time STAFF PSYCHIATRIST interested in community psychiatry. Flexible 40 hr. wk., including lunch hours, does not require night calls. 1 mo. pd. vacation, paid sick leave cumulative to 120 days total. Opportunities to attend selected lectures and seminars on clinic time & expense. Limited private practice. Salary to $33,000, depending upon qualifications. Contact: Dr. Thomas Di Mauro, Dir., Stark County Community Mental Health Center, 618 Second St., N.W., Canton, Ohio 44703 or call collect 216/455-9407.

ASSOCIATES WANTED: Cincinnati based professional corporation seeks full or part-time associates. Openings available in Emergency rooms, community clinics, or Industrial Medical Centers. Medical Health Services, Inc., 5902 Robison Rd., Cincinnati, Ohio 45213. Phone: 513/631-0200.

VACATION CONDOMINIUM — New Smyrna Beach, Fla. — just south of Daytona and away from the crowds, but enjoying the same beautiful beach. Two bedrooms, 2 baths, wall-to-wall carpeting, completely and tastefully furnished including linens, color TV and dishwasher, HEATED POOL, and sauna. $400 per month. For reservations or further information, contact Wm. W. Conner, M.D., 517 Lakeshore Dr., Eustis, Florida 32726. Phone 904-357-5717.

INTERNIST AND PEDIATRICIAN WANTED—Incorporated group of three general surgeons and one obstetrician-gynecologist looking for board qualified or certified internist and pediatrician. We are located in north central Wisconsin serving a community of approximately 25,000 with a summer population of 200,000. We have excellent recreational and educational facilities including college. Anyone interested write to Dr. I. E. Schiek Jr. or Dr. Otto G. Rosemeyer c/o The Schiek Clinic S.C., Rhinelander, Wisconsin 54501 or call collect 715/362-6160.

— More Classified Ads on Next Page —

CLASSIFIED ADVERTISEMENTS

(Continued from Previous Page)

WANTED: Family practitioners, pediatricians, internists, and obstetricians for dynamic municipal Midwest Health Department providing innovative primary care. Faculty appointment available. Salary $27,500-$30,000 negotiable. Must be eligible for Ohio license. Reply P.O. Box 238, Cincinnati, Ohio 45202.

EMERGENCY ROOM PHYSICIAN to work in 250 bed hospital with new Emergency Room. Excellent facilities and working conditions. Salary $40,000 annually for working every 4th day with excellent fringe benefit package. Hospital located 40 miles north of Columbus, Ohio. Contact David G. Paff, M.D., 399 East Church Street, Marion, Ohio 43302. Phone: 614/382-1133.

SURGICAL HOUSE PHYSICIAN WANTED to start immediately to supplement existing resident staff. Excellent salary for well qualified man. Excellent fringe benefits. Contact: Dr. John Woodhams, Director, Medical Education, Huron Road Hospital, Cleveland, Ohio 44112.

EMERGENCY ROOM PHYSICIAN — Modern, 350-plus bed general hospital located in pleasant midwestern city of 45,000 pop. seeks E.R. Physician to cover expanding service. Will join staff of four experienced E.R. Physicians in new facility. Salary range: $35-000-$40,000. Please send resume to Box 698, c/o Ohio State Medical Journal.

FOR RENT: SANIBEL CONDOMINIUM, new two bedroom, Gulf beach front condominium with pool and tennis courts, Sanibel, Florida. Reply Box 697, c/o Ohio State Medical Journal.

INDUSTRIAL PHYSICIAN—Immediate opening for M.D., either G.P. or Industrial medicine, to direct the medical facilities of a medium-size (1000) plastics manufacturing plant. Responsible for pre-placement and annual physicals, on-the-job illness and injuries, medical compliance with state and federal regulations. Excellent clinic with full time R.N. Write R. O. Jackson, Plant Manager, Monsanto Company, Addyston, Ohio 45001.

EMERGENCY ROOM PHYSICIANS wanted urgently. Full medical group membership, with partnership in 2 years. Competitive starting income with annual progressions and liberal fringe benefits. For further information, write or call Sam Packer, M.D., Medical Director, Ohio Permanente Medical Group, 2475 East Boulevard, Cleveland, Ohio 44120. Phone: 216/795-8000.

PHYSICIAN WANTED—IMMEDIATE EMPLOYMENT—House physician, medical. Must have completed residency in internal medicine. Foreign medical graduate must have ECFMG and permanent visa. Salary commensurate with training and experience. Benefits include sick leave, paid hospitalization, two weeks vacation annually, malpractice insurance and uniforms. Contact Mr. P. K. Beauchamp, Assistant Administrator, Fairview General Hospital, 18101 Lorain Avenue, Cleveland, Ohio 44111.

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IN MATERNAL AND CHILD HEALTH

1. Graduate Program for Physicians in Mental Retardation and Related Disabilities
2. Maternal and Child Health
3. Community Pediatrics
4. Community Obstetrics

Further information
Dr. Ruben Meyer, Director of MCH Program
Dr. Arthur Fleming, Director of Graduate Program for Physicians in Mental Retardation and Related Disabilities

SCHOOL OF PUBLIC HEALTH II
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Ann Arbor, Mich. 48104

FAMILY PRACTITIONER CORP. has opening for two people in family practice. Will be moving into new office facility about July 1, 1974. Contact: Box 700, c/o Ohio State Medical Journal.

ENERGETIC DIRECTOR to organize Family Practice Residency in Ohio. Prefer A.B.F.P. plus some practice experience. 700 bed hospital—Family Practice has full departmental status. Cooperation from all other departments assured. Director will organize and direct curriculum plus recruitment of residents as well as Family Practice Unit layout. Salary competitive. Contact Box 699, c/o Ohio State Medical Journal.

FAMILY PRACTITIONER needed to replace retiring member of 3 man group in rural S.W. Ohio, 45 minutes from Cincinnati. Have large well equipped office with own lab., x-ray, and regis. lab. tech. Accredited Co. Hosp., 12 miles. All specialty consult. Readily available. Salary 1st year, then full partnership if mutually agreeable. Equal call and time off. Sardinia Medical Clinic, Sardinia, Ohio 45171. Phone: 513/446-2531.

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HEALTH COMMISSIONER — Perform administrative and professional duties in directing health programs of general health district. Masters in Public Health or M.D.s only. Salary negotiable. Good fringe benefits. Send resume to: Mr. Harold Seeberger, Box M., Tiffin, Ohio 44883.

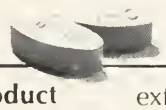
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

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Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

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Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
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15-30	2 tablets every 24 hours
Below 15	Use not recommended

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The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

VOLUME 70 MARCH 1974 NUMBER 3

THE FRANCIS A. COUNTWAY LIBRARY OF MEDICINE BOSTON

MAR 25 1974

Original Articles

Heroin Maintenance Clinics. A Discussion of the U. S. Addiction Treatment and the "British System." David G. Logan, M.D., Cleveland. 165

Bongo Drum Hematuria. Hassan Mehbod, M.D., Dayton. 169

E.N.T. Case of the Month. Andrew W. Miglets, Jr., M.D., Columbus. 171

Maternal Health in Ohio: Maternal Deaths Due to Stroke. By the OSMA Committee on Maternal Health. 172

Erratum: In January article "Awareness of Sickle Cell Abnormalities" 179

Your State Society at Work

A Message from the President Regarding Innovations in The Journal 175

What The Council Did at Its January 19-20 Meeting in Columbus 177

Necessary Increase in OSMA Dues Recommended by The Council 186

Ohio Places Last Among States in Amount of Dues Paid 189

OSMA Committee on Maternal Health Celebrates 20th Anniversary 198

1,850 Members Get Dividend Return on OSMA Sponsored Group Plan 185

Governor's Task Force on Health

Complete Text of Minority Report (insert following page 192)

1974 OSMA Annual Meeting

Make Your Hotel Reservations Now 180

Your Choice of Six PG Courses 190

OSMA's Olde But Goode Night (a Unique Social Function)

OMPAC Luncheon Make Your Reservations Now 193

"Run for Your Life" — Sponsored by Sections on Pediatrics, Sports Medicine and Physical Medicine 195

Art Show Planned as Annual Meeting Special Attraction 196

OSMA Annual Meeting Promotion Brochure Wins Top Honors Nationally 198

Deadline for Submitting Resolutions for 1974 Annual Meeting 158

Working with Others

Sports Medicine Powwow Brings Together Physicians, Hi Coaches, etc. 176

Public Health

Health Director Sets Groundwork for Hemophilia Program in Ohio 142

Community Health News: Be on the Alert for Scarlet Fever, Measles, Rubella 148

State Medical Board

Enforcement Actions for the Year Reported by State Medical Board 153

Government Medical Programs

How to Submit Error-Free Claims Forms Under Medicaid Program 156

Your AMA at Work

What the AMA Is Doing for High School Coaches and Students (facing page 193)

Keeping Up

Continuing Medical Education Courses for Physicians in Ohio 149

The Woman's Auxiliary

Highlights, Including Notes on the Coming Annual Meeting in Cleveland 200

Other Features

Is Your Office Lab Proficient, Doctor? If in Doubt, PEP May Help 146

Columbus Physician Receives Elizabeth Blackwell Award 142

Obituaries 160

The Journal's Advertisers

Index to Those Advertising in This Issue 202

Classified Advertisements 203

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This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
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MAR 25 1974

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Ohio State MEDICAL JOURNAL

VOL. 70 MARCH, 1974 No. 3

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17 South High Street, Suite 500
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Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

Subscription, $5.00 per year to nonmembers; single copy, 50 cents (outside Continental U.S., $6.50 and 65 cents).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertiser must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

Health Director Sets Groundwork for Hemophilia Program in Ohio

On December 17, 1973, Section 3701.144 of the Ohio Revised Code became effective for the establishment of a hemophilia program within the Ohio Department of Health.

The legislation provides for the Director of Health to establish a program to assist persons who require continuing treatment with blood and blood derivatives to avoid the crippling, extensive hospitalization and other effects associated with hemophilia.

Legislation also calls on the Director of Health to establish standards to determine eligibility for care, treatment or assistance under this program. The Director will also institute and carry on education programs to promote the understanding of hemophilia and of the methods of care and treatment of persons suffering from this condition.

State Health Director Dr. John W. Cashman recently appointed a 17 member Advisory Committee on Hemophilia, comprised of both consumers and professionals, to help establish a variable hemophilia program in Ohio. The committee is presently working to consider the best methods of distributing the $250,000 biennium allocation (1973-75) of the General Assembly.

Columbus Physician Receives Elizabeth Blackwell Award

Frances K. Harding, M.D., of Columbus, was selected by Hobart and William Smith College as the 1974 recipient of the Elizabeth Blackwell, M.D., award. The anniversary of the graduation of the first woman doctor trained in the Western hemisphere was chosen by Hobart College to honor the graduation of Dr. Blackwell from Geneva Medical College. The United States Postal Service joined in the recognition by issuing a commemorative stamp to mark the occasion. This is the first postal stamp issued by the U. S. Postal Service honoring a woman physician.

The award has been presented to seventeen women, among them being Frances Perkins, Magaret Mead, Marian Lasher, Marian Anderson, Helen Taussig and Catherine McFarland. Dr. Harding was selected for her pioneering work in family planning both in Australia and the United States and as immediate past president of The American Medical Women's Association.

The program reenacting Dr. Blackwell's graduation in the Presbyterian church at Geneva, New York, followed by a banquet at Hobart College and a visit to the Blackwell Room in the college library was on January 23, exactly 125 years after the original graduation.

Physician...

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61866





*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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2 gm and 4 gm vials

sterile spectinomycin hydrochloride

erile Trobicin
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gm vials cantaining 10 ml when recanstituted th diluent.
n aminacyclital antibiatic active *in vitra* against ost strains af *Neisseria ganarrhaeae* (MIC 7.5 20 mcg/ml) Definitive *in vitra* studies have awn na crass resistance af *N. ganarrhaeae* tween spectinamycin and penicillin

dications: Acute ganarrheal urethritis d practitis in the male and acute ganarrheal rvicitis and practitis in the female when due susceptible strains af *N. ganarrhaeae*.

ontraindications: Cantraindicated in pa-nts previausly faund hypersensitive ta spec-amycin.

'arnings: Nat indicated far the treatment af philis. Antibiatics used ta treat ganarrhea ay mask ar delay the symptams af incubating philis. Patients shauld be carefully examined d manthly seralagical fallaw-up far at least manths shauld be instituted if the diagnasis af syphilis is suspected.
Safety far use in infants, children and pregnant wamen has nat been established.

Precautions: The usual precautians shauld be abserved with atapic individuals.
Clinical effectiveness shauld be manitared ta detect evidence af develapment af resistance by *N. ganarrhaeae*.

Adverse reactions: The fallawing reactians were abserved during the single-dase clinical trials: sareness at the injectian site, urticaria, dizziness, nausea, chills, fever and insamnia.
During multiple-dase subchranic talerance studies in narmal human valunteers, the fallawing were nated: a decrease in hemaglabin, hematacrit and creatinine clearance; elevatian af alkaline phasphatase, BUN and SGPT. In single- and multiple-dase studies in narmal valunteers, a reductian in urine autput was nated Extensive renal functian studies demanstrated na cansistent changes indicative af renal taxicity

Dosage and administration: Keep at 25° C and use within 24 hours after recanstitutian with diluent.

Male—Inject 5 ml intramuscularly far a 2 gram dase. Patients with ganarrheal practitis and patients being re-treated after failure af previaus antibiatic therapy shauld receive 4 grams (10 ml). In geagraphic areas where antibiatic resistance is knawn ta be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—Inject 10 ml intramuscularly far a 4 gram dase.

How supplied: *Vials, 2 and 4 grams—with ampaule af Bacteriastatic Water far Injectian with Benzyl Alcahal 0.9% w/v.* Recanstitutian yields 5 and 10 ml respectively with a cancentratian af 400 mg spectinamycin per ml (as the hydrachlaride). Far intramuscular use only.
Susceptibility Pawder—far testing *in vitro* susceptibility af *N. ganorrhaeae*.
Cautian: Federal law prahibits dispensing withaut prescriptian.
Far additional praduct infarmatian see your Upjahn representative or cansult the package insert.

Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic esistance is known to be prevalent, initial treatment with 4 grams is preferred.

Is Your Office Lab Proficient, Doctor?

**If you are in doubt,
the Proficiency Evaluation Program (PEP)
is available**

Independent and hospital laboratories have long been subject to outside proficiency standards established by the Center for Disease Control (CDC) in Atlanta and their own state departments of health. Commercial laboratories doing business across state lines are also subject to strict federal standards of control. Recently, legislation in California, Arizona and Maryland has made it mandatory for physicians' office laboratories in those states to participate in proficiency testing.

Much has been said but very little documented about the reliability of laboratory tests performed in the physician's office. Now there is available a program which can document the reliability of laboratory tests in the doctor's office and also provide a mechanism for laboratory improvement if needed.

This program is called PEP (Proficiency Evaluation Program). It is sponsored by the College of American Pathologists and endorsed by the American College of Physicians and the American Academy of Family Physicians. Participation is confidential and, excluding office labs in California, Arizona and Maryland, entirely voluntary.

The program offers the physician an inexpensive system for monitoring the capabilities of his office laboratory. It allows the physician to evaluate specific tests, reagents, and instruments for accuracy and precision. It assists the physician in managing his laboratory techniques and personnel and assures him of quality test results. It helps to maintain high standards of patient care.

Detailed information can be obtained from the College of American Pathologists, 230 N. Michigan Avenue, Chicago, Illinois 60601.



When a cough spoils your patient's day...

Triaminic® Expectorant

Each teaspoonful (5 ml.) contains:

Triaminic, 25 mg. (phenylpropanolamine hydrochloride, 12.5 mg.; pheniramine maleate, 6.25 mg.; pyrilamine maleate, 6.25 mg.); glyceryl guaiacolate, 100 mg.; alcohol, 5%.

When an antitussive is also desired, the same formulation plus 10 mg. codeine phosphate is available as **Triaminic Expectorant with Codeine.** (A Schedule V Controlled Substance.)

The Adult Expectorant that is great for kids, too.

Dorsey Laboratories/Division of Sandoz-Wander, Inc./Lincoln, Nebraska 68501

BO–SB

Community Health News

Ohio Department of Health

John H. Ackerman, M.D., Deputy Director

1. The Ohio Department of Health Laboratories are recording a higher than usual percentage of throat cultures positive for Group A Streptococci. On the basis of partial reporting there seems to be an increase in the number of cases of scarlet fever. Physicians should suspect a streptococcal etiology in patients with sore throat and fever.

2. Localized measles outbreaks have occurred in a few areas in Ohio. Cases have been occurring in older children, often junior high school students. Most of the cases gave no history of previous infection or immunization. Less than 5% were vaccine failures. The other cases occurred in children who were vaccinated prior to age one or who were vaccinated with the combination of vaccine and immune globulin. We recommend revaccination of children who were vaccinated at less than one year of age with the immune globulin combination.

Because of the unusual age incidence in these outbreaks, the early cases were frequently not diagnosed as measles.

3. Some questions have arisen regarding the utilization of serologic testing for rubella antibodies. The following general information may be helpful.

The first reason for testing is to determine immune status. In general, titers higher than 1:32 or 1:40 indicate either past infection or successful immunization. Lower titers may be due to either past infection, immunization, or to the presence of natural inhibitors in the blood and cannot be relied on to indicate immunity.

The second utilization is in case of exposure of a pregnant female to a case of rubella. If a blood specimen is tested immediately it may show titers not greater than 1:32, indicating previous immunity. If there is no titer or a low titer, a second specimen should be taken five weeks later. A four fold increase in titer indicates infection has occurred. No change indicates no infection.

The third purpose is for diagnosis of a rash illness in a pregnant female. Blood should be drawn immediately and a second specimen at 10-14 days. A four fold increase in titer indicates rubella infection.

Contact the Ohio Department of Health, Communicable Disease Division, or the Division of Laboratories for any other questions concerning rubella testing.

OSMA AUTO LEASE PROGRAM SPECIAL OF THE MONTH

A Deluxe personal car leased for $107.50 a month for 28 months. Your option to purchase for $2110 on completion of lease period. Longer, shorter lease periods available. Optional equipment of your choice

Buick



Century Luxus Colonnade Hardtop Coupe

Includes 350 V-8, auto. trans., air conditioning, power disc brakes, power steering, AM radio, vinyl roof, white wall tires, body side moldings.

A limited number of Vegas, Pintos and Mustangs IIs available for immediate delivery.

Lease prices quoted on all American and foreign models for lease periods of varying duration — Audis, Porsches and Mercedes available for immediate delivery.

For information, dial toll-free 800-282-0256, or write OSMA lease plan, Ohio State Medical Association, 17 S. High St., Columbus, Ohio 43215

Administered by Immke Circle Leasing, 32 S. Fifth St., Columbus, Ohio 43215 Phone 800-282-0256

(A service for members sponsored by your Ohio State Medical Association)

Continuing Education Opportunities for Physicians in Ohio

March

Ohio State University College of Medicine; for details contact OSU Center for Continuing Medical Education, 410 W. Tenth Ave., Columbus 43210:

Ophthalmology — March 4-5.

Pediatric Clinic Day — At Children's Hospital, Columbus, March 13.

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106:

Advances in Urology, March 13-14.

Refresher Seminar in Pediatrics for Pediatricians and GPs, March 20-21.

Endocrine Pathology — Anatomic and Clinical, March 27-28.

University of Cincinnati College of Medicine (CONMED); Contact CONMED, 114 Medical College Bldg., Eden and Bethesda Aves., Cincinnati 43219:

Annual VA Hospital Symposium, at the VA Hospital, Cincinnati, March 14.

Lederle Symposium — Sponsored in cooperation with the Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214, at the Sheraton-Columbus Motor Hotel in downtown Columbus, March 24.

Ninth Annual Cancer Symposium — Akron City Hospital, 525 E. Market St., March 20-21.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

April

Family Relations Work — Sponsored by the Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; place of meeting, Sawmill Creek Lodge, Huron; April 19-21.

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106:

The Challenge of Reconstructive Orthopaedic Surgery, April 3-4.

Infection Control, April 17-18.

Ohio State University College of Medicine, Continuing Medical Educational Conferences; for details, contact OSU Center for Continuing Medical Education, 410 W. Tenth Ave., Columbus 43210:

Spinal Cord Injuries, April 18-19.

Care of the Burned Patient, April 24.

University of Cincinnati College of Medicine, Office of CONMED, 114 Medical College Bldg., Cincinnati 45219:

Ophthalmology — Cosponsored by the Ohio Society for the Prevention of Blindness, April 19.

(Continued on Page 152)

Synthroid®
(sodium levothyroxine)

the smooth road to thyroid replacement therapy.

***Synthroid* is T_4.**
It provides your patients with what is needed for complete thyroid replacement therapy.

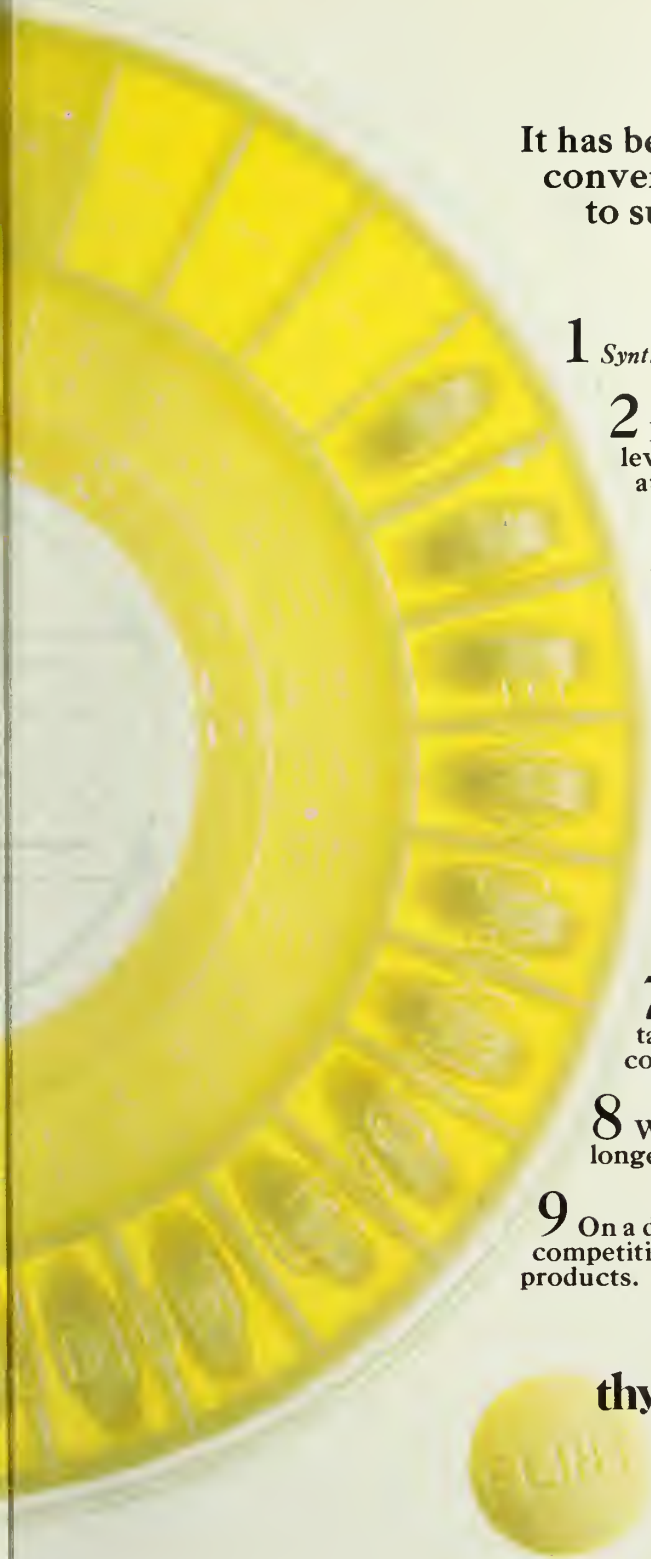


Free Tab-Minder sample packages available from Flint Professional Services Department.

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage of SYNTHROID (sodium levothyroxine) may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, such as Addison's Disease (chronic adrenocortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.



It has been shown that *Synthroid* (T4) converts to T3 at the cellular level to supply metabolic needs. [1, 2]

1 *Synthroid* is T4.

2 Because T4 converts to T3 at the cellular level, it provides full thyroid replacement at maintenance doses.[1, 2]

3 T4 hormone content is controlled by chemical assay.

4 *Synthroid* is assayed chemically; no biologic test is necessary to measure potency.

5 *Synthroid* provides predictable results when used with current thyroid function tests.

6 *Synthroid* is the most prescribed brand name of thyroid in the U.S. and Canada.

7 Sodium levothyroxine in *Synthroid* tablets is chemically pure. It does not contain any animal gland parts.

8 When stored properly, *Synthroid* has a longer shelf life than desiccated thyroids.

9 On a daily basis, *Synthroid* is cost competitive with other thyroid products.

The smooth road to thyroid replacement therapy.

Synthroid®
(sodium levothyroxine)

In most cases with side effects, a reduction of sage followed by a more gradual adjustment ward will result in a more accurate indication the patient's dosage requirements without the pearance of side effects.

sage and Administration: The activity of 0.1 mg. SYNTHROID (sodium levothyroxine) BLET is equivalent to approximately one grain roid, U.S.P. Administer SYNTHROID tablets a single daily dose. In hypothyroidism with- myxedema, the usual initial adult dose is mg. daily, and may be increased by 0.1 mg. ery 30 days until proper metabolic balance is ained. Clinical evaluation should be made nthly and PBI measurements about every 90 ys. Final maintenance dosage will usually ge from 0.2-0.4 mg. daily. In adult myxedema, rting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyreotic Human Subjects, J. Clin. Invest. *49*:855-64, 1970.
2. Surks, M. I., Schadlow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. *51*:3104-13, 1972.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

Educational Opportunities in Ohio — *Continued*

April (Continued)

Treatment in Psychiatry—Theory and Practice — At U. S. Brecksville VA Hospital, 10000 Brecksville Road, Brecksville 44141; cosponsored by the Medical College of Ohio at Toledo and Northwestern Ohio Institute for Continuing Medical Education, April 1-5.

May

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106:

Symposium on Hydrocephalus Pathogenesis Diagnosis and Treatment — May 1-2.

Plastic Surgery for the General Surgeon — May 8-9.

Advances in Antibiotics and Infectious Diseases — May 22-23.

Ohio State University College of Medicine, Continuing Medical Education Conferences; for details contact OSU Center for Continuing Medical Education, 410 W. Tenth St., Columbus 43210:

Newborn Conference — May 1-2.

Blood Therapy — May 8.

University of Cincinnati College of Medicine, Office of CONMED, 114 Medical College Bldg., Cincinnati 45219:

Speech Pathology — At the Shrine Burns Institute, May 10.

Abdominal Surgery — At Shrine Burns Institute, May 15-16.

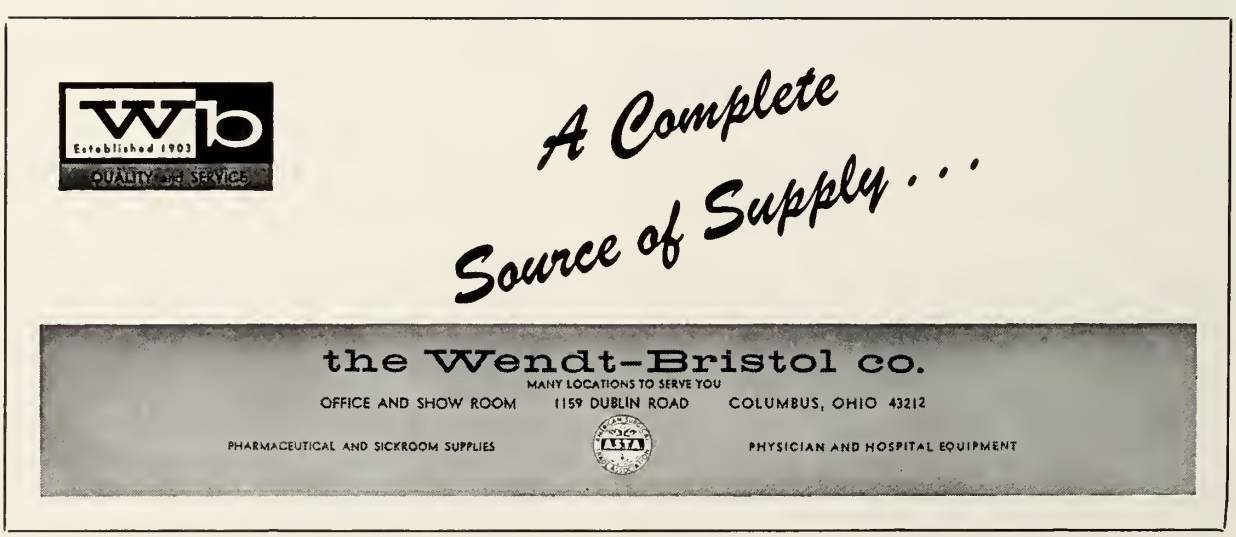
Midwest Ophthalmology Symposium — At Shrine Burns Institute, May 17-18.

June

University of Cincinnati College of Medicine (CONMED); Contact CONMED, 114 Medical College Bldg., Eden and Bethesda Aves., Cincinnati 45219:

Renal Disease Symposium — At Shrine Burns Institute, June 6.

Fourth Annual Radiological Seminar — Veterans Administration Center, 4100 W. Third St., Dayton; May 29, from 8:30 a.m. to 4:15 p.m.; contact: Emil Gutman, M.D., Chief, Radiology Service, Veterans Administration Center, Dayton 45428.



Enforcement Actions for the Year Reported by State Medical Board

FOUR Doctors of Medicine voluntarily surrendered their licenses to the State Medical Board of Ohio during 1973 and the Board suspended licenses of three other MDs and one Doctor of Osteopathy (DO). This information is contained in the annual report of the State Medical Board for 1973, as announced by William J. Lee, Jr., chief administrative officer of the Board.

The four MDs who surrendered their licenses included one with a drug problem, one with a mental problem, and two elderly doctors who were questioned regarding dispensing of narcotic drugs. A podiatrist with a personal drug problem surrendered his license to prescribe.

The suspensions of up to six months involved two MDS who were illegally dispensing controlled drugs, an MD for aiding and abetting illegal practice of medicine, and a DO for illegally dispensing narcotics.

At the end of the year, 8 cases were still pending. These included three MDs questioned regarding illegal dispensing of controlled drugs; two chiropractors involved in advertising contrary to law, and one involved in the practice of acupuncture; a mechanotherapist involved in dispensing of drugs, and a mechanotherapist-podiatrist involved in practice beyond the scope of his license.

Twenty-seven arrests in 1973, made by Medical Board investigators working with local police, included the following:

For unlicensed practice, six cases involving massage, four of podiatry, three of chiropractic, two of medicine (acupuncture) and two of medicine (hypnosis).

For aiding and abetting illegal practice of medicine, one chiropractor and two MDs.

One arrest for illegally piercing of ears, and one for a nonlicensed person advertising as a medical practitioner.

Five unlicensed persons were charged with opening and conducting offices for the practice of medicine, surgery or any of its branches.

Thirty-four informal hearings were held in the Medical Board offices, conducted by the administrator, enforcement chief and Board secretary. These involved 17 MDs, four DOs, three mechanotherapists, two masseurs, a podiatrist, and two cosmetic therapists. There were 29 hearings before the Board.

The Board met for 16 days during the year and its four investigators probed 525 cases, including cases in all 88 Ohio counties.



WINDSOR HOSPITAL
A NONPROFIT CORPORATION
— ESTABLISHED 1898 —
Chagrin Falls, Ohio
247 - 5300
A hospital for the treatment of Psychiatric Disorders
High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.
Accredited by Joint Commission on Accreditation of Hospitals.
Booklet available on request.
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MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals

75
YEARS

Professional *Protection*

CONTINUOUSLY

Since 1899

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

OHIO OFFICES:

CINCINNATI: Room 700, 3333 Vine Street, (513) 751-0657, L. A. Flaherty
CLEVELAND: Suite 106, 23360 Chagrin Boulevard, Beachwood 44122, (216) 464-9950
A. C. Spath, Jr., R. A. Zimmermann
COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel
TOLEDO: Suite 212, 4334 W. Central Ave., (419) 531-4981, R. E. Stallter



Android®-25 Tablets

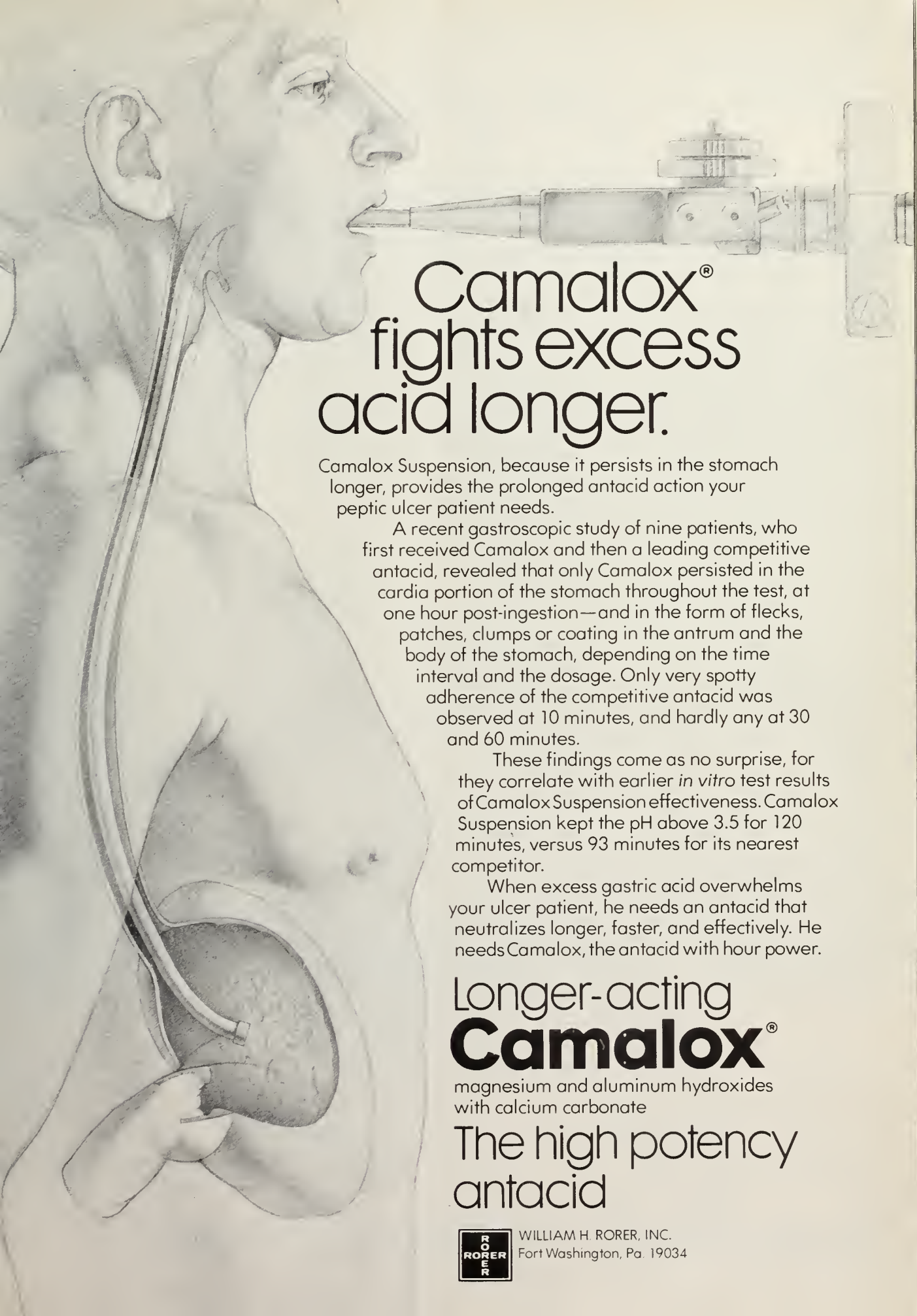
Android-10 Tablets **Android-5** Buccal

Methyltestosterone N.F. –25, 10, 5 mg.

For the treatment of impotence due to androgenic deficiency in the male.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylendrost-4-en-3-one. **ACTIONS:** Methyltestosterone is en oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Mele climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestetic hepatitis with jeundice end eltered liver function tests, such as increased BSP retention and rises in SGOT levels, heve been reported efter Mathyltestosterona. These chenges appeer to be related to dosage of the drug Therefore, in the presence of eny changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and lluid retantion. This may present e problem, especially in patients with compromised cardiac reserve or renel disease. In treating males for symptoms of climecteric, evoid stimuletion to the point of increasing the nervous, mantel, and physical ectivities beyond the patient's cardiovascular capecity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspectad carcinoma of the prostate end in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** Ii priepism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia end decrease in ejaculetory volume. Use cautiously in young boys to avoid premature epiphyseel closure or precocious sexuel development. Hypersensitivity and gynecomestie may occur raraly. PBI may be decreased in patients taking androgans. Hypercalcemie may occur, particularly during therapy for metestatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermie and decreesed ejaculatory volume • Hypercalcemia particulerly in patients with metastatic breast carcinome. This usually indicates progression of bone metastases • Sodium end water retention • Priapism • Virilization in female patients • Hypersensitivity end gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosege must be strictly individualized, as patients very widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosaga guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Mele climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th St., Los Angeles, CA 90057 REFER TO PDR



Camalox® fights excess acid longer.

Camalox Suspension, because it persists in the stomach longer, provides the prolonged antacid action your peptic ulcer patient needs.

A recent gastroscopic study of nine patients, who first received Camalox and then a leading competitive antacid, revealed that only Camalox persisted in the cardia portion of the stomach throughout the test, at one hour post-ingestion—and in the form of flecks, patches, clumps or coating in the antrum and the body of the stomach, depending on the time interval and the dosage. Only very spotty adherence of the competitive antacid was observed at 10 minutes, and hardly any at 30 and 60 minutes.

These findings come as no surprise, for they correlate with earlier *in vitro* test results of Camalox Suspension effectiveness. Camalox Suspension kept the pH above 3.5 for 120 minutes, versus 93 minutes for its nearest competitor.

When excess gastric acid overwhelms your ulcer patient, he needs an antacid that neutralizes longer, faster, and effectively. He needs Camalox, the antacid with hour power.

Longer-acting **Camalox®**

magnesium and aluminum hydroxides with calcium carbonate

The high potency antacid

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

Medicaid

How to Submit Error-Free Claims Forms

OVER THIRTY PERCENT of physician invoices submitted to the Ohio Department of Public Welfare are rejected by the computers because of errors made in physicians' offices. Computer rejection means that these claims have to be handled individually, causing undue loss of time to the Department and to the physician. The Ohio State Medical Association maintains close liaison with the Welfare Department, and is doing everything in its power to help the Department maintain an efficient and speedy service on Medicaid patient claims. The computer rejection rate can be cut down considerably if physicians and their assistants spend a little more time in submitting claims. From time to time, *The Journal* will present tips on how to fill out the forms more efficiently. Here are some points to remember.

1. If at all possible, type the physician invoice. If the invoice is not typed, be sure all items entered on the invoice are legible. A keypunch operator has to be able to read your invoice in order to code it into computer language.

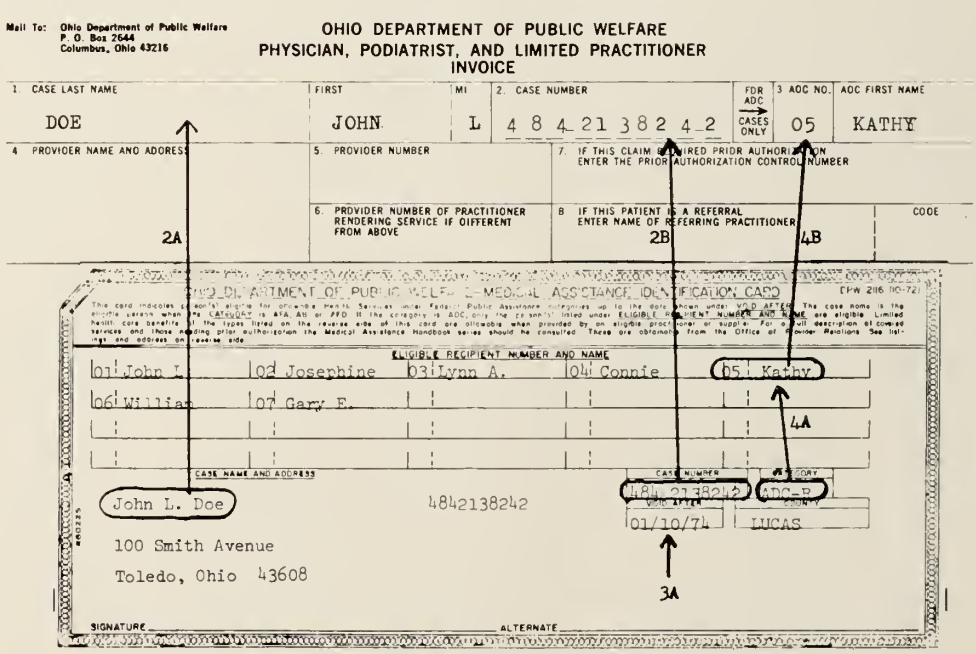
2. Items 1 and 2 on Ohio Department of Public Welfare Invoice Form DPW2434 deals with the case name and case number of a Medicaid recipient. Enter the last name, first name, and middle initial exactly as it appears on their Medical Assistance Identification card. See illustration, line 2A. Enter the 10 digit case number exactly as the number appears on the Medical Assistance Identification card. See illustration, Line 2B.

3. Be sure to check the "Void After" date on the Medicaid recipient's Medical Assistance Identification card. The state of Ohio will not pay for services rendered to an ineligible person. See Line 3A of illustration.

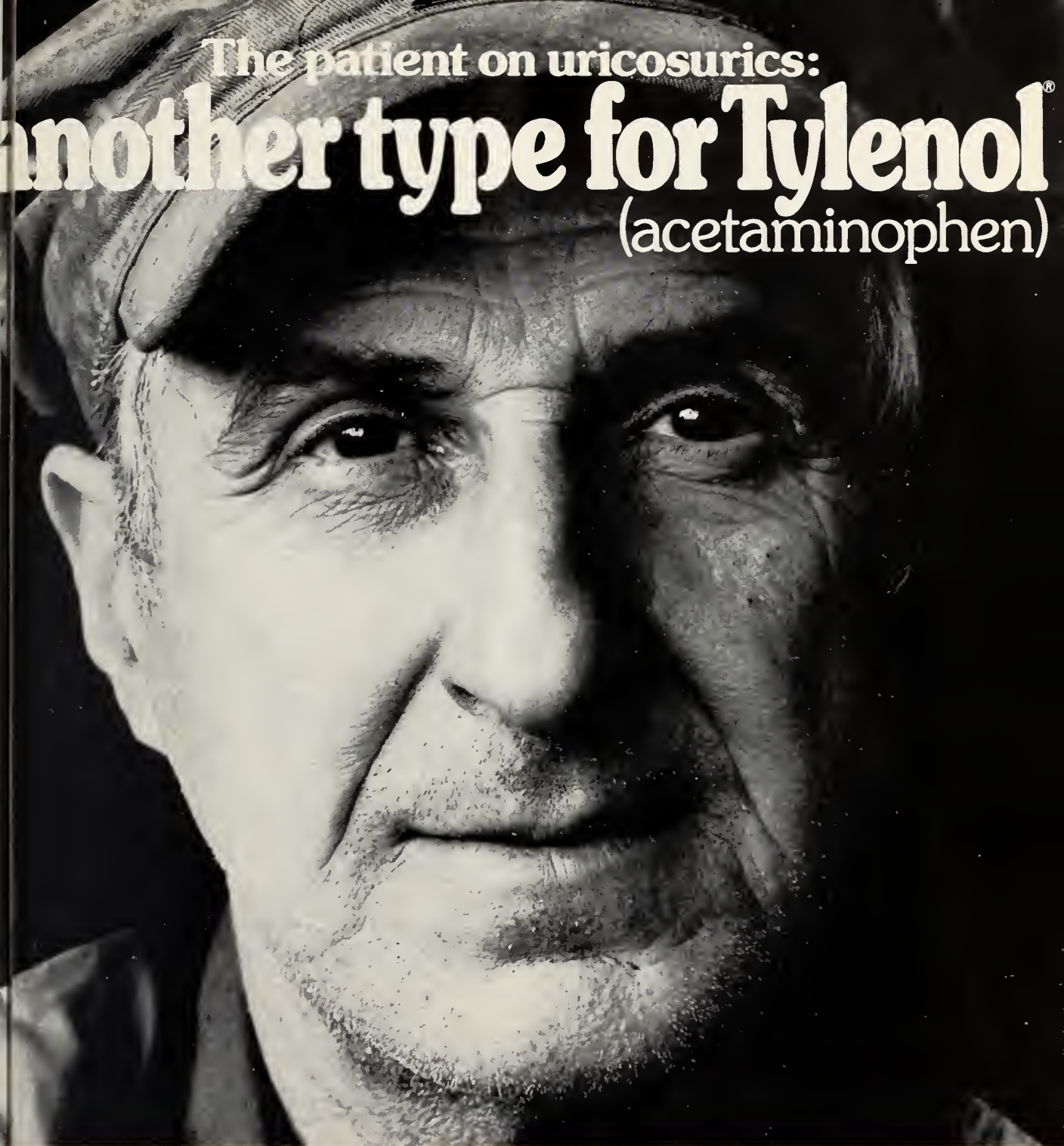
4. Item 3 on the Ohio Department of Public Welfare Invoice Form DPW2434 refers to a Medicaid patient that is on ADC Program. See Line 4A. You must enter the patient's two digit number and first name as shown on the Medical Assistance Identification card. See Line 4B.

The male adult in the case	01	Man's first name
The female adult in the case	02	Woman's first name
A child in the case	03-16	Child's first name
Example:	05	Kathy

The four topics just mentioned cause the greatest number of error rejections, because of not being legible, case name and case number not agreeing, and ADC numbers and the ADC name not given. Many times a claim is rejected by the computer because the patient's name is misspelled, digits in the case number are transposed, or the full ten digits are not given. A careful check of these items can limit errors and thus speed up payments.



The patient on uricosurics:
another type for Tylenol®
(acetaminophen)



When the patient on uricosuric therapy requires an analgesic, a new problem arises. Aspirin in the usual analgesic doses inhibits the action of uricosurics.[1,2]

TYLENOL (acetaminophen), on the other hand, causes no appreciable uricosuric antagonism[2] and for this reason is preferred over aspirin in the gout patient.

This is only one of several types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Martin, E.W., et al., ed. Hazards of Medication, Philadelphia, J.B. Lippincott Co., 1971, p. 511. **2.** Seegmiller, J.E.: Med. Clin. North Amer. 45:1259-1272 (Sept.) 1961.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg.
For Children:
Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin,
yet just as effective for relief
of pain and fever

Tylenol®
(acetaminophen)

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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Deadline for Submission of Resolutions to OSMA Office is March 13

Delegates to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1974 Annual Meeting should be guided by Chapter 4, Section 8 of the OSMA Bylaws entitled "Resolutions."

"Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least sixty (60) days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates."

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

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Obituaries

John Allan Altdoerffer, M.D., Youngstown; Northwestern University Medical School, 1929; aged 75; died Jan. 9; member of OSMA and AMA.

Morris Irwin Berkson, M.D., Youngstown; University of Maryland School of Medicine, 1924; aged 77; died Jan. 20; member of OSMA and AMA.

Robert H. Cassidy, M.D., Milwaukee, Wisc.; OSU College of Medicine, 1940; aged 61; died Jan. 17.

Josiah Hart Cornell, M.D., Cincinnati and Mitchell, Ky.; Eclectic Medical College, Cincinnati, 1926; aged 83; died Jan. 9; member of OSMA and AMA.

Russell Boyd Crawford, M.D., Cleveland; Northwestern University Medical School, 1917; aged 83; died Dec. 31; member of OSMA and AMA.

Neil W. Cummins, M.D., Toledo; OSU College of Medicine, 1948; aged 61; died Dec. 28; member of OSMA and AMA.

David A. Fink, M.D., Billings, Mont.; University of Cincinnati College of Medicine, 1965; aged 34; died Jan. 20.

Virgil H. Hay, M.D., Lima; OSU College of Medicine, 1912; aged 84; died Jan. 9; member of OSMA and AMA.

Louis Stephen Kish, M.D., Cleveland; Western Reserve University School of Medicine, 1927; aged 71; died Jan. 3; member of OSMA and AMA.

Howard Lauer, M.D., Dayton; OSU College of Medicine, 1930; aged 68; died Jan. 16; member of OSMA and AMA.

L. Connor Moss, M.D., Washington, D. C.; University of Cincinnati College of Medicine, 1930; aged 72; died Dec. 22.

Govan Andrew Myers, M.D., Cleveland; Meharry Medical College School of Medicine, 1923; aged 78; died Jan. 17; member of OSMA and AMA.

Robert Samuel Oyer, M.D., Wapakoneta; Hahnemann Medical College of Philadelphia, 1943; aged 58; died Jan. 14; member of OSMA and AMA.

Calvus Elton Richards, M.D., Cincinnati; Emory University School of Medicine, 1930; aged 67; died Jan. 15; member of OSMA and AMA.

Harold Coy Schmuck, M.D., Canton; Western Reserve University School of Medicine, 1929; aged 72; died Dec. 27; former member of OSMA and AMA.

Alvin John Tight, M.D., Ft. Lauderdale, Fla. (formerly, Sandusky); St. Louis University School of Medicine, 1936; aged 63; died Jan. 7; former member of OSMA and AMA.

Starling Cisco Yinger, M.D., Springfield; Jefferson Medical College of Philadelphia, 1929; aged 70; died Dec. 31; member of OSMA and AMA.

Max Maser Zinninger, M.D., Cincinnati; Johns Hopkins University School of Medicine, 1921; aged 78; died Dec. 27; member of OSMA and AMA.

Physician's Bookshelf

Current Medical Diagnosis & Treatment, by Marcus A. Krupp, M.D., and Milton J. Chatton, M.D., both of Stanford University School of Medicine, and other authors; Lange Medical Publications, Los Altos, Calif.; $12.00. This is the 1974 updated edition of the former *Current Diagnosis & Treatment,* and is one of a number of ready reference texts by this publishing company. This book is intended to serve the practicing physician as a useful desk reference on widely accepted technics currently available. It is not intended to be used as a text book, but does contain numerous references to the medical literature. The text, containing some 980 pages, is followed by a cross index.

The American College of Chest Physicians has set April 30 as the deadline for abstracts of papers that sponsors wish to present at the 40th Annual Scientific Assembly in New Orleans, November 3-7. Abstracts or inquiries should be directed to John T. Sharp, M.D., program chairman, American College of Chest Physicians, 112 E. Chestnut Street, Chicago, Illinois 60611.

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Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

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Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

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The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

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Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

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Clinical & Scientific Features



VOLUME 70 MARCH 1974 NUMBER 3

Heroin Maintenance Clinics

A Discussion of the U.S. Addiction Treatment and the "British System"

DAVID G. LOGAN, M.D.

METHADONE MAINTENANCE has proven itself an indispensable tool in the treatment of heroin addiction. The Dole-Nyswander studies of the mid-1960's[1] demonstrated addicts treated with methadone blockade were remarkably free of street drug usage and related crimes of revenue. The majority of these patients remained in treatment and returned to reasonably adaptive life styles within the confines of the law. Since this pioneering work, numerous clinical studies have recorded similar success with methadone treatment.[2,3] Despite critical attacks from a variety of sources,[4,5] the rapid spread of the availability of the medication and the growth of the number of addicts in treatment attest to its acceptance by both physicians and patients. More than 80,000 heroin addicts are now enrolled in some 400 methadone maintenance programs in 300 U.S. cities.[6]

Although methadone maintenance has brought a new era of hope and enthusiasm to opiate addiction treatment, there are several major unresolved problems:

(1) *Only an estimated one-fourth to one-third of addicts volunteer for methadone treatment.* For example, addiction treatment has been available upon request to all eligible persons for three years in Washington, D.C. Yet, despite the almost universal awareness of the availability of methadone treatment in that city, large numbers of addicts have not made use of it. (About 4,000 of an estimated 18,000 to 20,000 addicts are currently in treatment.)[7]

(2) *Twenty to 50 percent of patients drop out of methadone treatment each year and presumably return to street drug use.* In the experience of Drs. Dole and Nyswander where clinic sizes were small and case loads relatively low, dropout rates of 20 percent were observed. More recently, in programs which have grown rapidly despite limited financial resources and trained and counseling staff, nearly one half of the patients may leave treatment each year.

(3) *Methadone maintenance is not available for young persons early in the course of their addiction.* Since methadone is itself an addicting substance, methadone maintenance is not responsibly used in "non-established" addicts. Furthermore, as in viral illness, addiction is transmitted by persons in the earliest stages of their affliction. Thus methadone maintenance

Submitted August 24, 1973.

is not appropriate or even legally available[8] to treat the persons responsible for the unremitting growth of the problem.

Heroin maintenance is being proposed as a solution to the shortcomings of methadone maintenance. The argument is paraphrased simply as follows: "To reach a larger percent of an addicted population and to encourage them to stay in treatment, we must provide them with the drug they seek, not a substitute."[9]

This is an argument used by British physicians who have long been critical of the U.S. treatment of addiction as a criminal rather than a medical problem. They believe that the inadequacies of our treatment methods are a result of the constraints imposed on the medical profession by government narcotic officials. By contrast, they point with pride to the British addiction treatment methods, which include heroin maintenance.[10] Official spokesmen of both the British government and medical profession claim that this system has proved successful in curbing the growth of addiction in England.[11]

During the last two weeks of April 1972, I visited London in a brief but intensive tour of inspection of addiction treatment facilities. My intent was to return for six months to a year at a later date should I find treatment procedures there useful and worthy of importing to the United States. A brief recounting of some of my experiences and the reasons for rejecting the British form of heroin maintenance treatment follows.

An Overview of the London Addiction Scene

My first stop in London was at the Home Office where the famous British Narcotic Registry is kept.[12] I spoke with the director of the Drug Dependence Statistics Office there. He was a very cordial person and I found him willing to discuss the narcotic problem in light of information his office had accumulated. He told me that prior to 1960, nearly 100 percent of addicts in England were registered. The total number was just under 200. These addicts were exclusively physicians and persons who had become medically addicted. In about 1960, it was discovered that a few jazz musicians arrested for a variety of non-narcotic offenses were addicted. In 1962, coincidental with the rise of adolescent interest in "mod" clothes and hard "rock" music, additional numbers of young people were discovered to be using narcotics. Between 1962 and 1968, there was a very rapid growth of addiction among this group. These "hippie" youth procured their narcotics from a small group of so-called "renegade" physicians believed to have been "mentally deranged or psychopathic." These doctors wrote narcotic prescriptions without the slightest pretense of the medication being intended for medical purposes. The registry recorded a tenfold increase in the number of addicts during this period, from 200 to 2,000 persons. Previously adequate clerical methods designed to prevent reregistration of previously identified addicts were overwhelmed. Thus, addicts registered by separate sources were often counted twice. Although this statistical error exaggerated the growth of addiction, it is generally agreed that during the mid-1960's, the number of addicts in London increased dramatically. In response, Parliament passed a new Dangerous Drug Act in 1967, which limited the privilege to prescribe maintenance narcotics to a small number of government-sponsored addiction treatment clinics. There are 16 such clinics in London now. In 1969 and 1970, the number of new addicts being registered with the Home Office declined. The Home Office and the British medical profession cite this decline as evidence for the success of their treatment methods.

Even before I had finished my contact with the Home Office, I discovered a controversy over the significance of these figures and the success of the current treatment system they are claimed to substantiate. One of the lesser officers with whom I had contact expressed concern that the addiction problem really was not held in check. He feared that increasing numbers of young people have turned to street drugs rather than take the trouble to register in the official treatment clinics. Furthermore, he believed there was truth in the rumor that Hong Kong "Chinese heroin," imported originally to satisfy addicted Chinese restaurant help, was becoming increasingly popular on the street. As evidence, he cited the inflation of the price of a packet of "Chinese" from £1 ($2.50 in U.S. dollars) in 1968, to £5 at current street prices ($12.50). This heroin has become increasingly pure during the last three years as the supply sources have become more sophisticated.

The Official Outpatient Clinics

Following my contacts at the Home Office, I visited two of the official outpatient treatment centers, as well as inpatient treatment centers for both adults and adolescents. I was struck by the cordiality with which I was treated despite the large number of interested physicians who have been visiting from the United States, the Continent, and from other parts of England. Many physicians in these clinics were foreign but of greater interest than their origin were their sheer numbers. In contrast to the United States where each physician involved in addiction treatment is confronted with hundreds to even thousands of street addicts, I would judge that there is one full-time physician for each 50 to 100 addicts in London. In the inpatient center for adolescent addicts there were over 20 staff for 10 youngsters!

There was a general recognition in the clinics that requests for increased medication were typi-

The Author

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cally not motivated by genuine underdosage. Nevertheless, clinic physicians often respond to their caring impulses and the vague notion that a certain amount of diverted excess opiate is a good thing. As a result, addicts are frequently prescribed remarkably large maintenance dosages with little evidence that it is necessary. A pharmacist told me of a patient who receives 115 ten-mg heroin tablets each day.*

Since milligram for milligram more methadone is prescribed in England now than heroin, I had believed the British were changing from heroin to methadone maintenance as we know it in this country. I was shocked to find the majority of methadone prescribed is in the form "Physeptone," ie, injectable methadone. As a result, abscesses, hepatitis, and venous thromboses are as large a problem as they are in this country. An additional surprise was that, though it is infrequent, occasional patients are maintained on cocaine or even methadrene. Maintenance heroin is prescribed at the 16 official drug dependence units. Prescriptions are sent directly to pharmacies where the maintenance medication is dispensed in the form of soluble heroin tablets of Physeptone ampules.

Both addicts and physicians recognize that a major portion of the prescribed heroin is sold on the street. Several addicts with whom I spoke estimated 50 percent is diverted from registered patient use to the street market. This diversion of clinic heroin is defended with a strange but popular argument. The majority of physicians and others involved in addiction treatment within the established English system believe that the relatively free availability of diverted clinic heroin on the streets discourages the U.S. style of organized crime from establishing drug importation. One psychiatrist who did not share this view explained "they (government officials) believe Sicilians will arrive here with grapeskins still clinging to their feet to push heroin in our schools."

Despite the easy availability of heroin to registered clinic addicts, it has become increasingly difficult to enroll in a clinic. Prior to receiving treatment, an addict must endure up to three weeks of interviews with several social workers and at least one physician. Clinic personnel also make home visits and visit family and friends to establish the legitimacy of a young person's addiction before he will be treated. In addition several urinalyses positive for morphine are required.

Having proved his addiction to the clinic staff, the addict is abruptly treated with remarkable freedom. None of the medication need be consumed under surveillance of the clinic. Thus, persons can easily claim to have needs far in excess of their actual levels of tolerance. Urines to check for drugs of abuse other than the medication being prescribed are taken only sporadically and never under supervision. In three clinics, I observed young women who obviously were highly intoxicated by sedatives. There was no anger or sense of betrayal on the part of the staff as one would expect to see in a clinic in this country. In fact, in two instances there appeared no major effort to encourage these girls to alter their drug-taking behavior.

Social workers in the official clinics commented that young people come for treatment two to three years after their initiation to hard drugs. Apparently the long wait, pretreatment investigations, and clinic patient roles have nullified the attraction of the clinic heroin for the early heroin user. Once registered and on maintenance medication, clinic physicians and social workers regarded as successes the addicts who switched from intravenous medication to oral methadone. They spoke enthusiastically of the subsequent better grooming and job and family reordering which we see routinely with the institution of oral methadone treatment.

Non-Official "Free" Clinics

There are many nonestablishment drug treatment facilities in London. Most of these "drop-in centers" do not have medical capability. They are similar in spirit and staffing to the "crash pads" in the United States. These storefront organizations provide rooms where young people can congregate, warm themselves, and get something free or nearly free to eat. Commonly, the nonofficial drug treatment facilities have fixing rooms where addicts can inject medications. The clinic staff use artwork, picnics, and museum outings to establish contact and redirect the drug-oriented energies of their clientele. The young addicts accept the staff's efforts with apparent indifference. Their interest in the centers seems predominantly in the fixing

*Since the street price of a 10-mg heroin tablet is £1 ($2.50 U.S.), his potential income is over $250 a day. His actual illicit income depends, of course, on how much of the heroin he diverts from his own use.

accommodations and the inexpensive food and housing provided them.

A perceptive young social worker who managed one of the clinics described a transition in the activities of their project. At the outset, young people had congregated in large numbers and talk was exclusively drug related. But the clinic was evicted from its second-floor quarters when the greengrocer downstairs filed a complaint that syringes were being found among his cabbages. The staff examined the project's activities and decided free acceptance of the young people's behavior was abetting their drug usage. Also, widespread drug-oriented behavior at the clinic was encouraging youngsters who were not yet addicted to become so. Since that time, the staff's efforts have been to deromanticize the life of the addict by discouraging their milling about with young non-addicts. This administrator also felt that since the news media had become less interested in the drug problem, young people had found it a less attractive symbol of rebellion.

Finally, I visited a Chinese restaurant district in London where both addicts and nonaddicts said drug traffic was heaviest. Chinese restauranteurs were said to be selling heroin in large quantities directly on the street there. When I arrived, I was struck with the low level of any kind of street activity. I pointed out this discrepancy to a young "bobby." He explained this was the result of his simply doing his job. He then looked me over and threatened to "run me in" to the police station if he caught me talking to any young addicts. I saw this as further evidence of efforts to cool the excitement of the street drug scene but decided not to call his bluff. Nearby, Picadilly Circus was much more lively, and I did see two young people who were staggering from apparent alcohol or barbiturate intoxication. I saw no one who appeared to be "on the nod," ie, in a heroin-intoxicated state.

Discussion and Conclusions

The magnitude of the addiction problem in England and its rate of growth has been obscured since 1968, with the introduction of restrictive measures. In fact, the London addiction problem which the official medical community credits itself with containing, looks increasingly like the New York drug scene. Specifically:

(1) Street heroin is becoming increasingly more expensive.

(2) Treatment is becoming either much less available or much less attractive as judged by the increasing percentage of persons who are not registered.

(3) As a result, it is increasingly difficult to assess the number of addicts because of their failure to identify themselves for treatment.

Furthermore, I could find no suggestion, aside from the "Mafia paranoia," that the availability of heroin in treatment clinics was discouraging the use of illicit heroin. As mentioned before, the price rise of "Chinese" from £1 to £5 per packet in the last three years indicates the demand is rising. The heroin in the official clinic does not seem to be attracting young people into treatment earlier, nor is it keeping them in treatment more successfully than is methadone in the U.S.

The most encouraging aspect of the British addiction scene is that young people do seem to recognize the addict as a pathetic, rather than an heroic, creature. This realization, coupled with the increasingly restricted availability of heroin in the past several years, has led to a poorly documented but probably actual decline in the number of persons becoming addicted each year during the last several years.

Even with this brief exposure, I feel reasonably confident that a long period spent studying the British treatment system would not be very productive. Accordingly, I have returned to my treatment efforts here and will be content to observe statistics as they emerge from the Home Office. My prediction is that over the next five years, the British gradually will become disenchanted with their heroin prescription practices and gradually will develop a more restrictive system in which oral methadone is prescribed exclusively. But, since the British change slowly and the statistics and the official interpretation of them are in the hands of men who are eager to defend current practices, the time over which this change will take place may be long indeed.

Summary

Heroin maintenance clinics are being proposed in this country to answer several shortcomings of methadone treatment. In the spring of 1972, I visited the British Home Office, several heroin maintenance clinics, free clinics, and inpatient centers for treatment of both adolescents and adults. During the time when heroin was freely available through general practitioners in London (1960-1968) the growth rate of addiction was astronomical. The spread of heroin addiction in London does seem to have been brought to a relative standstill since institution of measures in 1968 requiring that only registered maintenance clinics be allowed to prescribe heroin. Despite the relative success of restriction of heroin prescription to these clinics, both the medical ailments and psycho-social concommitants of addiction persist in the clinic heroin addict. This is in direct contrast to the successful alleviation of these medical conditions and reduction of delinquent behavior in methadone-treated

patients in the United States. My conclusion was that introduction of heroin maintenance clinics in this country would be a major step backward.

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Bongo Drum Hematuria

Hassan Mehbod, M.D.

SINCE BARACH'S REPORT in 1910 of the association of hematuria and athletic activities,[1] several similar reports have appeared in the medical literature.[1-7] Hematuria and other urinary abnormalities have reportedly occurred in marathon runners,[1] basketball players,[1] boxers,[2,3] football players,[4] rowing crews,[5] swimmers,[6] and squat jumpers.[7] To our knowledge, hematuria occurring in a bongo drum player has not been reported to date. We recently observed such an association and hence this report.

Case Report

The patient, a 32-year-old black man, reported to the Renal Clinic, Veterans Administration Hospital, Dayton, Ohio, complaining of reddish-brown discoloration of urine of six weeks' duration. The patient stated that he played the bongo drum at a night club several evenings a week. From his description, this discoloration was of a paroxysmal nature and always appeared immediately after the patient played the bongo drum. It lasted for a few hours and the urine color gradually returned to normal within 24 hours or so. Past history and family history were noncontributory. The patient admitted to excess alcohol intake on occasions, but not for several weeks prior to this visit.

Physical examination revealed a man 177.8 cm (5 ft 10 in) in height, weighing 88 kg (194 lb), muscular and in no acute or chronic distress. The only abnormalities noted on physical examination were a blood pressure of 160/96 mm Hg and narrowing of arterioles on funduscopy. Microscopic examination of the urine sediment revealed many red blood cells and occasional red blood cell casts. Spectroscopy of the urine suggested the presence of hemoglobin and myoglobin. Results of the electrocardiogram, rapid-sequence intravenous pyelogram, chest x-ray, gallbladder series, urine cultures,

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Submitted October 11, 1973.

serum protein electrophoresis, sickle cell tests, and LE cell test were all normal. Endogenous creatinine clearance was 145 cc per minute. Hemoglobin fractionation revealed an AA pattern with 3.4 percent A_2 and 1 percent F (normal).

After obtaining the baseline studies (shown in the table), serum electrolytes, blood urea nitrogen, and complete blood count, the patient was asked to play the bongo drum for an hour, as he usually did at the night club. Immediately thereafter, blood was drawn from each arm, and urine was obtained to repeat the studies noted. It should be mentioned that although the urine was red and contained hemoglobin and myoglobin, the serum was of normal color.

After a few days of rest, this procedure was performed again. After a few more days of rest, he was asked to go to the gymnasium and engage in heavy exercises that involved trauma to his hands. Upon completion of the exercises, blood and urine were drawn for the studies, results of which are seen in the table.

The patient refused further studies including renal biopsy, muscle biopsies, and was discharged, but he agreed to regular checkups and follow-up in the renal clinic. Since discharge, he has played the bongo drum on a few occasions contrary to our advice, with the expected consequences. However, there has not been any change in the status of renal function. Follow-up urinary studies between drummings have been negative.

The following comments are applicable to the laboratory data in the table.

1. The elevation of serum bilirubin was attributed to alcoholic liver disease.

2. There was definite increase in plasma lactic dehydrogenase (LDH) and creatinine phosphokinase (CPK) after drumming but only minimal increase in LDH after running.

3. The presence of myoglobin, hemoglobin, and red blood cells in the urine was demonstrated after each drumming period but not after running.

4. There was no major difference between the studies performed on the blood taken from the right arm and the left arm except for a slight difference in LDH, which was 300 mU per ml from the right and 200 from the left.

5. Hematuria and other urinary findings gradually disappeared within 25 hours on both occasions.

Discussion

Barach was the first to report the association of hematuria and athletic activity.[1] His observations were from marathon runners and basketball players. Four decades later, Amelar and Solomon[2] and then Flood,[3] reported the appearance of hematuria in boxers. Hematuria was very severe in some instances following these activities. Indeed, its severity can be appreciated by the term Gardner used to describe it: "athletic pseudonephritis."[4]

Studies in a rowing crew [5]clearly demonstrated that a direct or even an indirect "trauma" to the kidney was not necessary for the appearance of hematuria. So, what is the mechanism of production of hematuria? Howenstine[7] proved the presence of myoglobinuria in recruits engaged in squat jumping. He noted that these patients had painful swelling of the quadriceps followed by the occurrence of myoglobin, hemoglobin, blood cells, protein, and casts in the urine.

In two patients, renal biopsy was suggestive of acute tubular necrosis. The fact that hematuria was found in our patient only when myoglobinuria

Comparison of Laboratory Data

Test*	Before Drumming†	After Drumming Study #1	After Drumming Study #2	After Running and Heavy Exercise	Normal
SGOT mU/ml	30	30	30	25	8-40
LDH mU/ml	175	220	250	200	100-200
CPK mU/ml	140	150	180	140	25-140
Alkaline phosphatase mU/ml	30	30	25	25	30-70
Bilirubin mg per 100 ml	2.1	2.0	1.9	2.1	0.3-1.0
Creatinine mg per 100 ml	0.95	1.0	1.0	0.9	0.7-1.3
Uric acid mg per 100 ml	5.3	5.5	5.2	5.0	2.5-8.0
Cholesterol mg per 100 ml	220	225	250	250	150-300
Phosphorus mg per 100 ml	3.3	3.3	3.8	3.8	2.5-4.5
Calcium mg per 100 ml	9.9	10.0	10.2	10.0	8.5-10.5
Albumin gm per 100 ml	5.2	5.1	6.0	6.0	3.5-5.0
Total protein mg per 100 ml	7.5	7.4	7.5	7.2	6.0-8.0
Coombs' test	Negative	Negative	Negative	Negative	
Serum haptoglobin mg per 100 ml	31	23	23		20-204
Urine	Clear	Reddish	Reddish	Clear	
Color	yellow	brown	brown	yellow	
pH	7.0	6.0	5.5	6.5	
Albumin	Negative	Positive	Positive	Negative	
Blood	Negative	Moderate	Moderate	Negative	
Hemoglobin	Negative	Positive	Positive	Negative	
Myoglobulin mg/L	0	272-544	272	0	Below 4

*Using SMA 12/60 and SMA 6/60 except for serum haptoglobin and urinary determinations.
†The periods of drumming and the heavy exercise were each of one-hour duration.

was present suggests a causative role for myoglobin in the production of the urinary changes.

Greenberg and Arneson[8] reported 23 cases of myoglobinuria associated with exertional rhabdomyolysis in a group of students enrolled in officer candidate school. Here again, urinary abnormalities of proteinuria, cells, and casts were noted.

Smith[9] noted the appearance of exertional rhabdomyolysis and associated urinary findings in certain individuals exposed to exertion. It is of interest to note that rhabdomyolysis is more common in poorly conditioned individuals; however, since it occurs in only a small group, the presence of undetermined predisposing factors is highly suggestive. These reports strongly implicate myoglobinuria in the production of the urinary changes, and the recent report of Hamilton and associates[10] leaves little doubt as to this relationship. There was no evidence of tubular necrosis in our patient. However, the injurious effect of myoglobinuria on the kidney has been well demonstrated by the report of Hamilton and associates.[10] Their patient developed acute tubular necrosis as the result of myoglobinuria. In our patient, the reason for drumming being the only activity associated with myoglobinuria could be the direct trauma to muscles in this type of activity.

Regardless of the reason for myoglobinuria, the fact remains that bongo drum playing was associated with the urinary changes on each occasion. Until other people engaged in bongo drum playing are studied, it seems reasonable to consider this activity as a possible source of trouble.

Summary

Although hematuria has been reported in association with various physical activities, it has never been associated with bongo drum playing. The case of a patient who developed hematuria after playing the bongo drum is reported here. Hematuria, in all likelihood, was caused by myoglobinuria.

References

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2. Amelar RD, Solomon C: Acute renal trauma in boxers. *J Urol* **72**:145-148, 1954.
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5. Alyea EP, Boone AW: Urinary findings resulting from nontraumatic exercise. *South Med J* 50: 905-910, 1957.
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E.N.T. Case of the Month

Andrew W. Miglets, Jr., M.D.*

This 67-year-old lady is referred to your office because of proptosis of her left eye (Fig. 1). She has been seen by an ophthalmologist, who found no evidence of ocular disease. Results of thyroid studies were normal.

What other structures should be evaluated as to the cause of her proptosis?

(See p. 174 of this issue for further information and discussion.)



Fig. 1. This lady has noticed the gradual onset of left proptosis.

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Submitted September 5, 1973.

Maternal Deaths Due to Stroke*

By the OSMA Committee on Maternal Health

PREVIOUSLY, the Committee has presented articles of a similar title, better known as "Cerebral Hemorrhage,"[1,2] with case reports to illustrate the development, management, and outcome of this bizarre catastrophe complicating pregnancy.

As early as 1959, Barnes and Abbott[3] studied 170 cases in the first ten years of the Franklin County Maternal Mortality Study; 36 of the 170 patients (21.1 percent) suffered cerebral complications, of which 17 were intracranial hemorrhage.

Herewith the Committee presents three cases from the Ohio Study, followed by a statistical discussion. One of the three patients died undelivered (third trimester); all cases were submitted to autopsy examination.

Case No. 1234

A 29-year-old, white, para III, abortus II, died two days postpartum. Of four previous pregnancies, two were spontaneously aborted (no dilation and curettement); the others were delivered at term, both complicated by toxemia *(high risk)*. She registered for the last pregnancy in the third month. Her weight was 49.4 kg (110 lb), physical findings and vital signs were normal, and she made five visits. The prenatal care was adequate. In the 34th week edema developed, her weight was 57.7 kg (127 lb), and she was admitted to the hospital for treatment (diuretics); urine and blood pressure were reported normal. The weight decreased 2.3 kg (5 lb) and she was discharged, only to be admitted a week later with severe epigastric pain. Blood pressure was 148/80 mm Hg, fetal heart sound 140 per minute, and temperature 36.7 C (98 F). Labor began spontaneously and was precipitous, lasting two hours; the fetal heart sound disappeared 40 minutes before the spontaneous delivery of a dead fetus weighing 2040 gm (4 lb 2 oz) at 8:40 PM on November 19. The third stage of labor revealed 50 percent abruptio placenta. Records reveal the postpartum blood pressure was 140/100 mm Hg, pulse rate 110 beats per minute; oxytoxic medication was given. The next day while on the bed pan, the patient suddenly became comatose, blood pressure was 180/130 mm Hg, pulse rate 120 beats per minute, pupils were constricted, fixed. Immediate therapy included oxygen, magnesium sulfate, and parenteral fluids. Oliguria developed; a spinal puncture at 5:40 AM revealed bloody fluid; the blood pressure was 136/100 mm Hg. At 7:00 AM, cardiac arrest developed, treated by external cardiac massage. She was placed on the respirator, and oliguria continued. The blood urea nitrogen (BUN) was 37 mg per 100 ml, creatinine level 16.6 mg per 100 ml, and the blood pressure was 110/68 mm Hg by 10 PM on November 20. Her clinical course progressed down hill and she died the following day.

Cause of Death (Autopsy): Massive hemorrhagic infarct of the brain stem; multiple confluent hemorrhagic infarcts of the liver; acute renal failure (clinical).

Comment

The Committee studied available facts in this case, noting certain academic and philosophical observations by the pathologist. He felt that eclamptic changes in the liver and kidneys were not definitely demonstrable. Nor could he account for the etiology of the massive pontine hemorrhage; no vascular malformation was demonstrated. The final conclusion: probable chronic renal disease and superimposed toxemia; placental insufficiency; unexplained cerebral vascular accident. Members voted the case a *nonpreventable maternal death.*

Case No. 886

This patient was a 34-year-old, Negro gravida X, para IX, who died undelivered in her eighth month of pregnancy. As a "grand multipara," she was obese (over 95.3 kg [210 lb]) and had had multiple hospital admissions for *hypertension (high risk patient)*, last blood pressure reading being recorded at 170/110 mm Hg. Details of past pregnancies were not available. Neither was there any information on her prenatal course (last pregnancy). On February 15, a neighbor found her out of bed and unable to get back into bed. The emergency squad was called and found the patient with no respirations, no pulse, and no heart beat. A 4-year-old son declared the patient fell and hit her head on a television set.

Cause of Death (Coroner's Autopsy): Hypertensive heart disease; intrapontine hemorrhage (hemorrhage does not break into ventricular system or the subarachnoid space); no skull fracture; no lacerations of any part of the head; uterine pregnancy approximately eight months (2700 gm).

Comment

Members of the Committee are always amazed to see how many "grand multipara" survive innumerable hazards; this one did *not.* With a history of (essential) hypertension and numerous

*Material originally furnished for discussion of a paper presented by C. E. Gibbs, M.D. at the meeting of the Central Association of Obstetricians and Gynecologists held at Scottsdale, Arizona, October 17, 1973. The paper with discussions is to be published in a forthcoming issue of *American Journal of Obstetrics and Gynecology.*

admissions therefor, the Committee felt (1) the patient should have read and followed advice on the prevention of subsequent pregnancies, and (2) she should have *sought* prenatal care at a very early month. The Committee voted this a *preventable* maternal death.

Case No. 1377

This 37-year-old, white, para O, cesarean IV, died four days postpartum (postoperative). There were three previous cesarean sections, the first for cephalopelvic disproportion; once she had a "reaction" and jaundice following blood transfusion. This, plus her obesity, previous cesarean sections, and anemia, placed her in the *"high risk"* category. The patient registered May 3; last menstrual period was December 27. Her height was 5 ft. 5 in., weight 90.3 kg (199 lb), blood pressure 148/94 mm Hg, and hemoglobin level 10.5 gm per 100 ml. On June 26, she was treated with iron, later Imferon, and subsequently diuretics for edema. Her first admission was September 10, after she developed edema and nausea. Multiple consultants diagnosed "thrombocytopenia and anemia," cause undetermined. She received *eight* units of packed blood cells; she felt better, and seemed clinically improved. A repeat cesarean section was scheduled for September 21. The patient suddenly developed convulsions and became comatose *before* surgery. Consulting neurosurgeons confirmed intracerebral hemorrhage (angiogram). The fetal heart remained strong and regular. At 4 PM on September 19 (ninth admission day), an emergency cesarean section delivered a living, 2800-gm (6-lb 4-oz) baby; this was followed immediately by a craniotomy and decompression, which confirmed hemorrhage and necrotic brain tissue. On the critical list, the patient received *platelets,* and hypothermia; but her clinical course deteriorated and she died on September 23.

Cause of Death (Autopsy): Intracerebral hemorrhage, left parietal lobe; encephalomalacia; gastrointestinal and urinary tract hemorrhage, marked anemia and thrombocytopenia, etiology undetermined; pregnancy uterine, delivered.

Comment

The Committee studied facts in this case noting the completeness of all details. Considerable discussion focused about the management of pregnancy complicated by thrombocytopenia, many argued that platelets should have been given on September 12. After prolonged deliberation, members voted this case a *preventable* maternal death (by a narrow majority).

Discussion

Usually this portion of the Committee's article is written anonymously. However, for the sake of confluence of subject and material, the following data presented October 17, 1973, as discussion of Dr. Gibb's paper by Dr. Ruppersberg, are summarized herewith:

"For a period of 17 years, 1955-1971, Ohio reported 3,601,702 live births (Table 1). From the Ohio Maternal Mortality Study, conducted by the Committee on Maternal Health, the following data for the *same 17-year period,* is compared to statistics from Texas:

"The Committee found 1,128 maternal deaths (both direct and indirect obstetric) during the period surveyed. Our maternal death rate was 31.3 per 100,000 live births, comparing favorably with Texas. We found 53 (or 0.47 percent) of the maternal deaths were due to cerebrovascular disease or stroke (Table 2).

"Twenty-seven of the 53 patients died of cerebrovascular accident (CVA), or stroke, *without* toxemia, while 25 patients had toxemia *with* hypertension and CVA; only one died from cerebral embolism.

"The range of ages among 53 patients was similar to Texas, the majority being among 25 to 29 years and 35 to 39 years, respectively.

"Autopsies were reported on only 56.6 percent of the 53 cases; the cause of death in the remaining cases was based upon clinical evaluation or radiologic evidence or specific pathology.

"We examined the interval between death and delivery (Table 3); 14 of the 53 patients died *undelivered* of which 12 more died in the first puerperal week. Thirty-three of the patients had

Table 1. Ohio Births, 17 Years 1955-1971*

Live Births	4,103,076
Stillbirths	501,374
Total Births	4,604,450

*From the Statistical Div., Ohio Department of Health

Table 2. Maternal Deaths Due to "Stroke," Ohio Maternal Mortality Study, 17 Years (1955-1971)

*Maternal deaths	1128	
CVA "stroke" (no tox.)	27	
Cerebral embolism	1	
Toxema (hypertens.) CVA	25	
Total	53	(0.47%)

*Direct + indirect obstetr. causes

Table 3. Interval Between Delivery and Death, 53 Maternal Deaths, Ohio Maternal Mortality Study

Died undelivered	14
1 — 7 Days	12
7 — 28 Days	9
12 — 24 Hours	8
Remainder	10

Table 4. Period of Gestation at Time of Death, 53 Maternal Deaths, Ohio Maternal Mortality Study

Term	33
28 — 36 Weeks	15
Remainder	5

Table 5. Preventability, 53 Maternal Deaths, Ohio Maternal Mortality Study

Nonpreventable		29
Preventable		24
Patient	7	
Personnel	12	
Both	5	

Table 6. "High Risk" Patients Among 53 Maternal Deaths from "Stroke," Ohio Maternal Mortality Study

High risk patients	29
Condition related to cause of death	18

term pregnancies (Table 4) while 15 had gestations of 28 to 36 weeks.

"The Committee voted 29 of the 53 cases *nonpreventable* maternal deaths. On the other hand, less than half (24) were considered preventable; half of these were the responsibility of personnel (Table 5). The status of contraceptive advice was omitted.

"Twenty-nine of the 53 females were *high risk* obstetric patients (Table 6); 18 of these had a cause of death *related* to the *high risk* condition!

"Obviously, this is a frustrating problem which is difficult to solve except through alert and adequate obstetric care. We wonder how many patients with stroke *survived*. Family planning and reliable contraception should be utilized in the *high risk* patient; obviously, *this* type of patient should have intensive, protective care.

"We certainly compliment Dr. Gibbs on an excellent presentation, and wish him continued success with his Texas Maternal Mortality Study."

Generic and Trade Name of Drug

Iron dextran injection — Imferon (Lakeside Laboratories)

References

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Discussion of E.N.T. Case of the Month

(continued from p. 171)

Because of the approximation of the paranasal sinuses to the orbit, tumors of these structures can present with ocular symptoms. In this particular instance, careful examination revealed the patient's nose and nasopharynx were entirely within normal limits. There was full range of ocular motion despite the proptosis.

Radiographic examination of the paranasal sinuses, however, revealed a clouding of her left maxillary sinus with evidence of bone destruction in the roof of the antrum (Fig. 2).

A Caldwell-Luc procedure was done in which the anterior wall of the maxillary sinus was removed, enabling a biopsy of the sinus lining to be taken. A fungating mass was present in the sinus, which proved to be a squamous cell carcinoma.

It has been shown recently that improved cure rates can be expected when squamous cell carcinoma of the paranasal sinus is treated with combined therapy (radiotherapy followed with definitive surgery). Accordingly, a full course of radiation therapy was given, followed by a maxillectomy and exenteration of her orbit. Since carcinoma, here, rarely metastasizes, a radical neck dissection is not usually done. This patient is alive and well, three years following combined therapy.



Fig. 2. Radiographic examination reveals clouding of left maxillary sinus (S) with evidence of bone destruction (arrows) in the roof of the sinus (floor of the orbit).

In This Issue of The Journal You'll Find Some Innovations

IN THIS, and in future issues of *The Journal,* the reader will find more emphasis on functions of the Ohio State Medical Association and an effort to show how activities of the Association relate to individual physicians. This is not a



Oscar W. Clarke, M.D.
President, Ohio State Medical Association

change of policy, since *The Journal* always has been and always will be published "for and by members of the Association." The change is one of emphasis and is being made at the direction of Association officers.

Foremost in this emphasis will be a series of articles on the work of the Association's numerous committees and an effort to show how the work of these committees relates to the practice of medicine. The OSMA has committees working in virtually every phase of activity relating to the medical profession. These committees are composed of physicians in medical education, in public health, in hospital affairs, in medicine and religion, in mental health, in school health, in sports medicine, in legislative activities, in government relations, and in other special fields as well as in every type of practice.

Additional articles will deal with Ohio Medical Indemnity, Medical Advances Institute Peer Review Systems, and other organizations and activities close to physicians. Articles will deal with OSMA and its relationship with the Ohio Department of Health, Ohio Department of Public Welfare, the Bureau of Workmen's Compensation, and other public agencies with whom physicians have a professional relationship.

The thrust of these articles will be to show how the Ohio State Medical Association and its activities are related to every physician in Ohio whether he be in practice or in some other professional endeavor.

The medical profession is today at the zenith of its ability to serve humanity, and the American people are receiving the highest form of medical and health care the world has ever known. Organized medicine has had something to do with these accomplishments and organized medicine will have something to do with maintaining that high standard. Improvements in the health care system must come about through evolutionary, not revolutionary procedures.

The Ohio State Medical Association is the voice of the medical profession in this State. Each category of physicians may have its own organization, and many of these organizations are prestigious in their own rights. But the voice of medicine in Ohio must be one voice.

The Ohio State Medical Association must be able to demonstrate to people in high places and in everyday walks of life that it speaks with authority. When well-meaning citizens sound off on medical and health subjects, a voice must be heard saying, "This is what the medical profession of Ohio thinks on that subject."

The Journal will do its best to act as the first line of communication between the Association and the physicians of Ohio.

To accomplish this emphasis on Association activities, it is necessary to make certain other adjustments in *The Journal's* contents.

The Clinical and Scientific Section will continue as a separate part of *The Journal.* Ohio physicians will be encouraged to submit articles of

merit for publication. There will be more selectivity, however, and somewhat fewer pages will be devoted to original articles.

The Woman's Auxiliary has been asked to reduce its monthly column.

The Table of Contents has been moved to the front cover where it is a ready reference for the busy physician.

The obituary column will be continued, but on a reduced basis. Only a listing of deceased physicians will be given with enough information to identify the individual in the eyes of his colleagues.

Obviously, there is an economic factor involved in the limited number of pages allotted. *The Journal* relies on advertising revenue for most of its budget, and advertising revenue is down. Hopefully, this situation will improve and adjustments will be made in *The Journal* allotments of space as conditions improve.

Oscar W. Clarke, M.D.
President,
Ohio State Medical Association

Sports Medicine Conference at Newark High School Stresses Health and Safety of Scholastic Athletes

MORE THAN 150 physicians, athletic directors, coaches, athletic trainers and student trainers attended the Southeastern Ohio Sports Medicine Conference at the Newark High School auditorium, January 24.

The conference was sponsored by the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association and Ohio High School Athletic Association, in cooperation with the Ohio Department of Education.

Highlighting the program were presentations on "Conditioning" by Sol Maggied, M.D., of West Jefferson, chairman of the Joint Advisory Committee on Sports Medicine; "Therapy for Minor Injuries" by Dale Googins, head athletic trainer at Denison University, Granville; "Nutrition for Athletes" by Ms. Susan K. Cable, Nutrition Consultant, Southeast District, Ohio Department of Health, Nelsonville; "Equipment Fitting" by John Bozick, equipment manager, Department of Athletics, Ohio State University, and "First Aid for Serious Injuries" by Henry D. Rocco, M.D. of Newark.

In charge of arrangements for the conference was Jim Allen, athletic director at Newark High School. Welcoming the participants and introducing the speakers was William M. Wells, M.D. of Newark, treasurer of the Ohio State Medical Association.

Dr. Maggied as Joint Advisory Committee chairman pointed out that this type of conference serves two primary purposes.

"It provides physicians and trainers who serve athletic teams with an opportunity to update their knowledge and to keep abreast of the latest developments in the prevention and treatment of, and rehabilitation from, athletic injuries," said Dr. Maggied.

The chairman added that coaches must play a major role in the prevention of injuries and illness, while at the same time being proficient in first aid techniques, especially if no athletic trainer or physician is available immediately following an on-the-field injury.

"In this regard," explained Dr. Maggied, "the State Board of Education has enacted a provision in the Minimum Standards for Ohio High Schools which calls for the faculty member (coach) responsible for students participating in interscholastic athletics to evidence knowledge about the medical aspects of sports activities. The faculty member (coach) should continually be apprised of the latest developments emanating from medical and training research on sports activities."

Thursday's conference at Newark High School was the first to be sponsored in Ohio during 1974 by the Joint Advisory Committee on Sports Medicine. During 1973 similar conferences were held in Bowling Green, Cleveland, Columbus, Cincinnati and Galion.

Proceedings of The Council

Meeting of January 19-20, 1974

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday, January 19, and Sunday, January 20, 1974, at the OSMA Headquarters' office, 17 S. High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council (with the exception of Dr. Bates); Mr. James E. Pohlman, Columbus, OSMA Legal Counsel; Mr. James S. Imboden, Columbus, Assistant Director of the AMA Public Affairs Division; Charles E. Kiely, M.D., Cincinnati, Associate Dean of the University of Cincinnati College of Medicine; Henry G. Cramblett, M.D., Columbus, Dean, Ohio State University College of Medicine, and Messrs. Page, Campbell, Clinger, Rader, Houser, Mrs. Wisse and Mr. Moore, of the OSMA staff.

Those present Sunday were: All members of the Council (with the exception of Dr. Bates and Dr. Thomas); Mr. Pohlman, H. William Porterfield, M.D., Columbus, President, Ohio Foundation for Medical Care, and Messrs. Page, Campbell, Clinger, Rader, Houser, Mrs. Wisse and Mr. Moore.

Approved Letter to OPSR

The Council voted to **ratify and approve** and support a communication regarding PSRO area designations from President Clarke to Henry E. Simmons, M.D., Acting Director of the Federal Office of Professional Standard Review, under date of January 15, 1974.

Minutes Approved

Minutes of the Council Meeting, December 15-16, 1973, **were approved.**

Membership

Mrs. Wisse announced membership statistics for the year ending December 31, 1973, which indicated a gain of 219 members for Ohio State Medical Association and 127 for the American Medical Association.

American Medical Association

Dr. Gaughan read a report on association activities, as submitted by John H. Budd, M.D., a member of the AMA Board of Trustees.

The Council **approved** for submission to the American Medical Association House of Delegates, in June, 1974, a resolution from the Academy of Medicine of Cleveland, with regard to medical devices.

OSMA Annual Meeting

A written report from Mrs. Dodson on the OSMA Annual Meeting was accepted for information and hosts were assigned for the 1974 Annual Meeting.

It was reported that a resolution has been received from the Delaware County Medical Society.

State Legislation

H.B. 790, to register physician's assistants—referred to OSMA Committee on Health Manpower.

H.B. 825, to establish a medical school loan commission to administer a medical school loan program—support in principle—amend to delete portion that would increase tuitions.

H.B. 1008, to expedite licensure of U.S. citizens who are graduates of foreign medical schools—endorsed in principle and concept. Reaffirmed House of Delegates' of the Fifth Pathway.

H.B. 1014, to provide for custody, evaluation and treatment of drug addicts—referred to the OSMA Committee on Mental Health.

H.B. 1017, to require labels on prescription drugs dispensed to bear special information, including generic name of drug—referred to the OSMA Committee on Pharmacy Relations.

H.B. 1090, to reform Ohio drug laws—referred to the OSMA Committee on Mental Health.

H.B. 1094, to require posting of retail prescription drug prices—opposed

S.B. 377, to license ambulances—referred to OSMA Committee on Emergency and Disaster Medical Care.

S.B. 414, to create a new state board to evaluate existing state boards and commissions—opposed.

(Continued on Next Page)

S.B. 444, to reform Ohio drug laws—referred to OSMA Committee on Mental Health.

S.B. 450, to license laboratory facilities and personnel—opposed.

Governor's Task Force Minority Reports

The Council received for information the minority report submitted by Drs. William R. Schultz and Peter Lancione, with regard to the Governor's Task Force on Health Care, and complimented them on the excellence of the report.

The Council also received for information the minority report on the Governor's Task Force on Health Care, submitted by Mrs. William A. Myers, Circleville, and her letter to the Governor, dated January 27, with regard to the way the Task Force study was conducted.

The Council asked that a letter be forwarded to the President of the Woman's Auxiliary, complimenting the Auxiliary on the selection of Mrs. Myers to represent the Auxiliary on the Governor's Task Force.

Committee Reports

Building Committee

Minutes of the meeting of the Building Committee, held December 16, 1973, **were approved** by the Council, as presented by Mrs. Wisse.

Executive Committee—Ohio Foundation for Medical Care

The minutes of the Executive Committee of the Ohio Foundation for Medical Care meeting of December 12, 1973, were presented by Mr. Rader and were accepted for information.

Board of Trustees — Ohio Foundation for Medical Care

The minutes of the Board of Trustees of the Ohio Foundation for Medical Care meeting of January 9, 1974, were presented by Mr. Rader. The Council expressed the opinion that the present mission of the Ohio Foundation for Medical Care is to establish a prototype and have a program ready on a standby basis. It was the consensus of Council that, in accordance with the "Report of the Ad Hoc Committee on Health Care Delivery Systems," 1973 House of Delegates, any implementation of such a prototype and paper would be at the "discretion of the Council."

Committee on Emergency and Disaster Medical Care

The minutes of the Committee on Emergency and Disaster Medical Care meeting of January 5, 1974, were presented by Mr. Rader, and were accepted for information.

Committee on School Health

Mr. Clinger presented the minutes of the Committee on School Health meeting of January 9, 1974. The Council requested additional information on the school nurse accreditation problem. The minutes were accepted for information.

Committee on Membership and Planning

Minutes of the Committee on Membership and Planning meeting of January 13, 1974, were presented by Mr. Page. The Council **approved** in the minutes a 30 per cent increase in *Journal* advertising rates; increased selectivity in the scientific section while the economic situation and paper shortage prevails; new reports by OSMA committee secretaries covering activities of their committees; listing of obituaries; limitation to one page of Auxiliary news; inserts for annual meeting program and proceedings; more legislative news items, and the printing of the table of contents on the cover page. The Executive Editor was instructed to prepare an alternative plan for the publication of *The Journal*, should paper stock become a limited resource in 1975.

The Council **approved** the membership incentive program of the AMA and voted to share any receipts of interest payments from the American Medical Association equally with the county medical societies.

A suggestion with regard to changing Section 4, Chapter 2 of the Bylaws with regard to dues deadlines was re-referred for more study.

The membership dues record card and the survey of the membership in connection with the new computerized membership record system was **approved.**

Commission on Medical Education

The minutes of the Commission on Medical Education meeting of January 16, 1974, were received for information.

Committee on Laboratory Medicine

The minutes of the Committee on Laboratory Medicine meeting of January 18, 1974, were presented by Mr. Rader. In connection with the committee's report, a recommendation that legislation to modify the existing statutes so that prenatal testing for gonorrhea be accomplished as near as possible to the time of delivery in the obstetrical facility in which the delivery will occur, **was approved.** The Council addressed a communication to John W. Cashman, M.D., Ohio Director of Health, asking his cooperation to help remedy the error in the statutes and to offer the assistance of the Ohio State Medical Association in so doing. The minutes were accepted as modified.

Deans Confer With the Council

Charles E. Kiely, M.D., Associate Dean of the University of Cincinnati College of Medicine, addressed the Council and discussed with the members of the Council problems of mutual

interest to the Ohio State Medical Association and the University of Cincinnati College of Medicine.

Henry G. Cramblett, M.D., Dean of the Ohio State University College of Medicine, addressed the Council with regard to developments at the Ohio State University College of Medicine, medical education of Ohio citizens and the selection process for medical students.

Spring District Conferences

The Councilors were urged to select dates and set up programs for the Spring District Conferences, which will include county officers, delegates and alternate delegates. A suggested worksheet and agenda were requested in connection with the development of these meetings.

Preadmission Medicare and Medicaid

The Council **approved** a proposed communication from President Clarke to HEW Secretary Caspar W. Weinberger, with regard to proposed preadmission requirements for Medicare and Medicaid, and directed that the communication be forwarded to Secretary Weinberger. The staff was instructed to send copies of the communication to all county medical society presidents and secretaries.

Direct Billing

With regard to a communication concerning hospital contracts, the Council reaffirmed the OSMA policy supporting direct billing and asked that a strong letter be directed to all county medical societies with regard to this reaffirmation. Such letter is to have the approval of legal counsel.

Acupuncture

A letter from a physician with regard to acupuncture was received by the Council. The Council asked that the member be advised of the policy of the Ohio State Medical Board.

Request for Audit

The Council considered and referred to Medical Advances Institute a request from the Chief of Staff and the Administrator of Providence Hospital, Sandusky, Ohio, for the audit of one if its medical departments.

Dayton Experiment

With regard to the Dayton Experiment, it was announced that the Executive Council of the Montgomery County Medical Society is presenting information on the Dayton Experiment to the American Medical Association, requesting that it comment to the Council of the Montgomery County Medical Society. The Council asked that the Executive Director write to the Rand Corporation for its appraisal and evaluation of the experiment.

Bylaws

Constitutional changes in the Bylaws of the Mahoning County Medical Society **were approved,** contingent on some technical corrections.

Revisions in the Constitution and Bylaws of the Stark County Medical Society **were approved.**

Amendments to the Constitution and Bylaws of the Fairfield County Medical Society **were approved.**

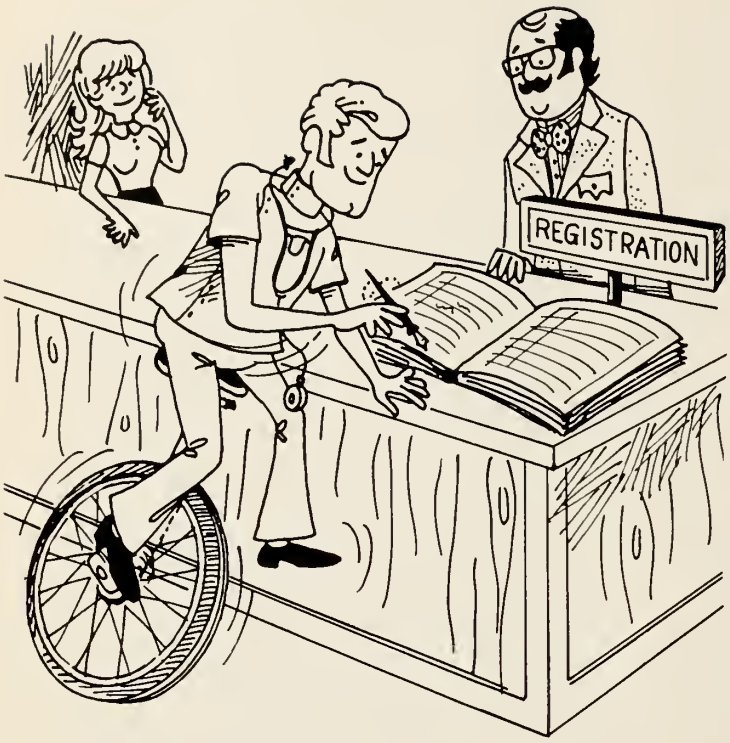
Future Meetings of the Council

It was announced that the next meeting of the Council will be scheduled for March 9-10, with a meeting of the Ohio Delegation to the AMA, to be held the evening of March 8.

The President announced a "Think Session" has been scheduled in the Cincinnati area for the weekend of April 5-6. Facilities are to be arranged by Dr. Hogg.

ATTEST: Hart F. Page
Executive Director

ERRATUM: In the article "Awareness of Sickle Cell Abnormalities" (January issue of *The Journal,* page 27), it was erroneously stated in a footnote that this study was supported by The Cleveland Clinic Foundation. The project was funded by the Department of Community Medicine, Case Western Reserve University School of Medicine (as correctly stated) and *The Cleveland Foundation.—The Editor*



MAKE YOUR HOTEL RESERVATIONS FOR THE 1974 OSMA ANNUAL MEETING

CLEVELAND, OHIO MAY 12-15

Headquarter's Hotel
SHERATON-CLEVELAND HOTEL
24 Public Square
Cleveland, Ohio

Single Occupancy	$17.00	$ 20.00	$ 23.00	$25.00	$28.00	$30.00
Double Occupancy	$24.00	$ 27.00	$ 30.00	$32.00	$35.00	$37.00
Suites (One Bedroom)	$65.00	$ 75.00	$ 80.00			
Suites (Two Bedroom)	$95.00	$120.00	$140.00 & Up			

HOTEL RESERVATION BLANK

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 12-15, 1974 (or for period indicated).

For_____
(Please Print)

Organization_____

Street_____ City_____ State_____

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(If other occupants in room, give names)

_____ Single Occupancy _____ Suites (One Bedroom)

_____ Double Occupancy _____ Suites (Two Bedroom)

Price Range _____ Other Accommodations _____

Guaranteed _____

ARRIVAL DATE: May_____ at _____ A.M. _____ P.M.

DEPARTURE DATE: May_____ at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION

Sign of a cold* sufferer

Time for Ornade®

Each Spansule® capsule contains 8 mg. Teldrin® (brand of chlorpheniramine maleate); 50 mg. phenylpropanolamine hydrochloride; 2.5 mg. isopropamide, as the iodide.

Fast relief of nasal congestion and hypersecretion* with convenient b.i.d. dosage.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

*

Indications

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Possibly effective: For relief of upper respiratory tract congestion and hypersecretion associated with vasomotor rhinitis and allergic rhinitis, and for prolonged relief.

Lacking in substantial evidence of effectiveness: For relief of nasal congestion and hypersecretion associated with the common cold and sinusitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules.

SK&F Smith Kline & French Laboratories
Division of SmithKline Corporation, Philadelphia, Pa. 19101





The irritations of man's day are often reflected in his gut.

The causes of irritable colon and the diarrheal symptoms that often accompany it can be as diverse as the systemic and emotional irritations man is faced with daily.

Although the mucoid nature of stools and the occurrence of diarrheal episodes coincident with times of emotional stress may be valuable clues to the functional nature of the disorder, irritable colon must often be diagnosed by exclusion. Such diagnostic exploration takes time. Discovery of the nature of any emotional problems may take more. During that time, Lomotil® is an ideal agent for controlling diarrheal symptoms.

Lomotil tablets are small, easy to carry and easy to take. They act promptly and effectively. Secondary effects are relatively infrequent and, once the first force of the diarrhea is controlled, maintenance is frequently effective on as little as one fourth of the initial dosage.

These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.



Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

takes care of the gut issue in irritable colon

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid*, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

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G. D. Searle & Co., Medical Department
Box 5110, Chicago, Illinois 60680

352

Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.



INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and $\frac{1}{32}$ oz. (approx.) foil packets.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

$215,925.77 Dividend Distributed



Hart F. Page, Executive Director of the Ohio State Medical Association, is shown signing a $215,925.77 dividend check, enabling Turner & Shepard, Inc., administrators of the OSMA sponsored Group Term Life Insurance Plan, to distribute the 1973 dividend to 2,093 participants. Looking on is Jerry J. Campbell, an OSMA Associate Executive Director and Secretary to the OSMA Committee on Insurance. Among the 2,093 participants in the plan who received dividends were 1,850 physician-members and 243 physicians' employees. The OSMA Group Term Life Insurance Plan is now entering its 16th year of successful earnings. The 1973 dividend was the largest amount ever returned to participants.

OSMA Term Insurance Plan Dividend Is Declared; Disability Plan Opened

A 43 percent dividend for the Ohio State Medical Association group term insurance plan and the availability of a new disability income protection plan were announced by Turner and Shepard, Inc., administrator of the OSMA insurance plan.

The 43 percent dividend for 1973 is the second highest in the history of the plan which started in 1958. Credit for the dividend will be reflected in the March billing to participants. A dividend of this size continues low-cost protection for members and their families.

The new Disability Income Protection Plan will have an open enrollment during February. Members not enrolled in existing regionally sponsored plans and less than 50 years old may enroll during the month for $150 per week protection without evidence of insurability.

A maximum disability benefit up to $500 per week is available to members under age 60. For information contact Turner and Shepard, Inc., 17 South High Street, Columbus, Ohio 43215. Telephone number is 614-228-6115.

Increase in State Association Dues Recommended by The Council

THE COUNCIL of the Ohio State Medical Association, after carefully considering the financial report of the Association at its meeting of December 15-16, voted to recommend to the House of Delegates that an annual dues rate increase be made effective January 1, 1975. The House of Delegates will consider and act upon the matter at the 1974 Annual Meeting in Cleveland May 12-15.

The Council's recommendation has set the annual dues at $110, beginning in 1975, a figure that will meet current financial needs and allow for moderate expansion of activities and services in the near future.

In order that the membership of the Association may be thoroughly informed as to the necessity for this proposed action, The Council has directed that information be made known to OSMA members through *The Journal,* official publication of the Association, and that the *OSMAgram* call attention to the available information.

In addition, The Council has directed that similar information be furnished to officers of County Medical Societies and to Delegates to the OSMA House of Delegates.

Factors Prompting the Necessity for the Dues Increase

General Inflation: The proposed increase will go into effect three years after the previous dues increase. In the mean time virtually every item of cost in the operation of the Association has gone up.

Cost of Office Space: Office rent in the downtown area has skyrocketed in the last several years. To forestall continuing to pay exorbitant rents, the Association has built its own headquarters building and will be moving into it soon. Eventually owning its own building will bring down the Association's housing costs considerably, but for the time being costs are high.

Postage: With more than 10,000 members of the Association, communication between the headquarters and members becomes a major factor. Postage has increased and another increase of 18 percent has been announced, effective March 2.

Legal Fees: With the ever increasing encroachment of the government into the practice of medicine, legal issues become more complex and legal entanglements become more numerous. Officers of the Association as well as the executive staff find more and more need for legal advice in dealing with association problems and in planning future moves.

Increased Salaries: Cost-of-living increases have necessitated increases in salaries. An expansion of the staff has become necessary because of the pyramiding activities of governmental agencies with which the Association must deal. The Ohio General Assembly is now meeting almost continuously instead of a few months every second year as in the past. This will require the hiring of two full-time lobbyists as soon as funds are available.

In its long-range planning, the Association needs field men who can be on the road constantly, visiting County Medical Societies and helping them with their programs, problems and long-range planning. It is recommended that two field men be hired as soon as the budget permits.

Meeting Costs: Meeting room space, meals, travel, all have increased considerably. The Annual Meeting cost is up, meetings of The Council and the Association's various committees, as well as various postgraduate activities, district conferences, etc., all cost more to stage.

Committees: The Association has committees in virtually every phase of activities in which the profession engages. These committees are effective only when they meet and report their findings back to The Council or the House of Delegates. More activities, more travel expense (gasoline, etc.), higher cost of meals, mean increased cost of operation.

Publication Costs: *The Ohio State Medical Journal* relies largely on advertising of pharmaceutical manufacturers and other supply houses for much of its operating costs. Advertising has declined considerably during the past few years, putting additional cost of operation on the Association. Printing and paper costs are increasing. *The Journal's* size has been cut drastically to compensate somewhat for increased cost.

General Costs: The general cost of doing business is caught up in the inflation spiral—office furniture, typewriters and other office machines,

stationery and other office supplies all have increased in price. The Association's share on employees' Social Security taxes has increased considerably. Other fringe benefits of employees also have increased.

Court Actions: In the offing are a number of court actions, necessary to preserve the rights of Ohio physicians. Court actions mean expensive procedures and money for legal counsel must be set aside. Funds are not now available for this purpose.

Printing and Paper: Skyrocketing costs have hit these two essential items of communication. It has been recommended that the Association install an offset lithograph press to help relieve this pressure.

What Services and Benefits Do You Get from Your OSMA Dues

The Ohio State Medical Association, like all branches of organized medicine, has evolved out of necessity. From earliest times physicians have found that they must work together for their own good as well as for the good of their patients and for the betterment of the public health. As the population increased and as life become more complex, organized medicine became more sophisticated. With the encroachment of government into the practice of medicine, organized medicine became still more diversified in its efforts to deal with the many issues of the day.

Here are highlights of roles played by your State Association in providing programs and services.

- Serves as a clearing house of medical and health information.
- Conducts an active public relations program by providing speakers for lay audiences, by distributing specially prepared literature to the public, by cooperating with the news media in keeping the public informed on medical and health matters.
- Represents the Medical Profession through selected spokesmen before the Ohio General Assembly, the U.S. Congress, and keeps physicians informed on legislative developments in the medical and health fields.
- Keeps contact with state and national agencies administering medical, health and welfare programs, offers advice and keeps physicians informed of activities and plans of these agencies.

Life Active Membership . . . Take a Second Look!

In view of the proposed increase in membership dues, physicians may wish to again consider the Life Active Membership offer, an even greater bargain when the anticipated dues increase goes into effect.

Life Active Membership status may be obtained for $1,250. This is an investment in future elimination of annual dues for most physicians anticipating normal lifetimes of practice. For the physician enjoying the peak of his career, the Life Active Membership is an investment in "satisfaction."

The Life Active Membership status was created by the OSMA House of Delegates at the 1973 Annual Meeting in anticipation of keeping the construction of the new OSMA Headquarters Building on a sound financial basis, and minimizing future interest on building costs.

Physicians who have paid their 1974 membership dues and wish to take advantage of this offer may deduct the amount of the 1974 dues and pay the difference of $1,185.

- Publishes *The Ohio State Medical Journal,* first line of communication between the Association and its members.
- Issues the *OSMAgram,* keeping members informed on current issues.
- Issues Legislative Bulletins to keep the membership informed on developments in the legislative field.
- Presents postgraduate medical training programs available to members; cooperates with schools and health agencies in planning and sponsoring scientific programs.
- Maintains liaison with Ohio's four medical colleges, seeking their advice and help in matters of educational interest, and offering them help and advice in their programs and activities.
- Maintains liaison with the State Medical Board in matters pertaining to licensing procedures and enforcement of the Medical Practice Act in Ohio.
- Maintains liaison with Ohio hospitals and cooperates in maintaining high quality of standards.
- Cooperates with the American Medical Association and maintains liaison with other State Medical Associations in providing services of value to the public and to the medical profession.
- Maintains an executive office in Columbus manned by trained personnel to aid physicians and

to promote the interest of the medical profession throughout the State.

• Maintains liaison with County Medical Societies, offering them help where needed.

Personal Services to Members

In addition to the general services of the Association, it promotes a number of programs and services of personal interest to physicians. Here are some of the things it does.

• Sponsors a group ordinary life insurance program, providing up to $20,000 life insurance, including accidental death and dismemberment, waiver of premium, etc.

• Sponsors a group term life insurance program, with up to $50,000 life insurance, including accidental death and dismemberment, waiver of premium, etc.

• Sponsors a major medical insurance plan with $20,000 major medical insurance coverage, with $300, $500, or $1,000 deductible provisions.

• Sponsors a hospital indemnity insurance plan that pays either $30 or $60 for each hospitalized day.

• Provides a disability income insurance plan, co-sponsored with County Medical Societies, with a wide variety of benefits including a lifetime accident and sickness to age 65 plan, and a lifetime accident and seven-year sickness plan.

• Sponsors a corporate employers group life insurance plan with $50,000 limit for medical corporations.

• Sponsors a travel program, offering its members, their families, and members of the Woman's Auxiliary a choice of four trips a year. The average number of people involved to date has been 200 per trip. Tours are of two weeks' duration and offer medical seminars covering a wide variety of medical interests for the continuing education of physicians.

• Sponsors an automobile leasing plan and recreational vehicle rental plan through a responsible automobile leasing firm.

• Offers an office furnishing and equipment leasing service.

• Acts as liaison with the Ohio Workmen's Compensation program when individual physicians encounter claims problems.

• Acts as liaison for individual physicians who have difficulties or misunderstandings with programs under Medicare, Medicaid, CHAMPUS' Crippled Children, V.A., etc.

• Offers to obtain authentic information on physician's tax matters.

• Offers to obtain authentic information on laws, regulations, court decisions, etc., as they pertain to physicians. (The Association cannot give legal advice, but will cooperate with a physician's attorney when appropriate.)

• Gives information and advice regarding matters relating to federal and state laws and regulations on controlled drugs.

• Furnishes physicians with information and background material for the preparation of talks.

• Acts as an information center for physicians and members of physicians' staffs who inquire about status of physicians, specialty qualifications, addresses, etc.

• Offers information on hospitals, extended care facilities, etc.

• Operates a physicians' placement service for the benefit of physicians and Ohio communities.

• Provides numerous pieces of literature on health for distribution by physicians.



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Providing Personal Service to Physicians and Surgeons with Qualified Personnel Available to Discuss Your Insurance Needs in Your Office.

WOLMAN INSURANCE AGENCY, INC.
PHONE 614/221-5471
38 JEFFERSON AVENUE, COLUMBUS, OHIO 43215



• Offers information to physicians who may wish to make local talks on drug abuse and related subjects.

• Offers information that may expose quacks, fake remedies, etc.

• Offers information on reliability of collection agencies.

• Offers to obtain information on the reliability of insurance companies.

• Furnishes members with information about candidates for public office.

• Offers information regarding laws and regulations pertaining to remodeling or building of professional facilities.

• Offers information on the availability of facilities for the physician's patient who may be chronically or mentally ill.

• Offers information on questions pertaining to professional ethics, etc.

Ohio Places Last . . .

in State Medical Association dues survey as published in the Journal of the Tennessee Medical Association

Yes, Ohio has the dubious distinction of being last on the list in amount of annual dues, as indicated in the following table, updated to 1974. The survey was made by the Tennessee Medical Association and published, as it appears below, on page 85 of the January, 1974 issue of *The Journal of the Tennessee Medical Association.*

It is reproduced here for the information of Ohio physicians.

SUMMARY OF ANNUAL DUES OF ACTIVE MEMBERS OF STATE MEDICAL ASSOCIATIONS*

Alaska	$450.	Arizona	120.
Nevada	260.	Oklahoma	120.
Montana	200.	New Hampshire	120.
South Carolina	180.	Oregon	115.
Utah	165.	Indiana	110.
Colorado	150.	Maryland	110.
Idaho	150.	Georgia	100.
Iowa	150.	Mississippi	100.
District of Columbia	145.	Nebraska	100.
Wisconsin	145.	New York	100.
Delaware	140.	Pennsylvania	100.
Hawaii	140.	Rhode Island	100.
California	135.	Vermont	100.
Michigan	135.	West Virginia	100.
New Mexico	135.	North Carolina	95.
Illinois	131.	New Jersey	90.
Kentucky	130.	Louisiana	85.
Alabama	125.	Massachusetts	85.
Arkansas	125.	Virginia	85.
Kansas	125.	Tennessee	80.
Maine	125.	Texas	80.
Minnesota	125.	Florida	75.
North Dakota	125.	Missouri	75.
South Dakota	125.	Puerto Rico	73.
Wyoming	125.	Connecticut	70.
Washington	122.	Ohio	65.

*For 1974

Register Now for Course I, II, III, IV, V, or VI

Six Postgraduate Courses

SCHEDULED TUESDAY AND WEDNESDAY MORNINGS

MAY 14 and 15 — 7:30 - 9:00 A.M.

SHERATON-CLEVELAND HOTEL

During 1974 OSMA Annual Meeting

The Ohio State Medical Association Committee on Scientific Work is continuing the new learning technique which was initiated several years ago. Six postgraduate Courses will run simultaneously on Tuesday and Wednesday morning, May 14 and 15, from 7:30 to 9:00 a.m. The respective Courses will be chaired by experienced physicians who will lead their groups of not more than 35 registrants.

Each Course is acceptable for three prescribed hours by the American Academy of Family Physicians.

COURSE I
"Acid Base Disturbances and Blood Gases"

Course Leader: **Edmond S. Ricanati, M.D.,** Director, Hemodialysis Unit, Cleveland Metropolitan General Hospital, Assistant Professor of Medicine, Case Western Reserve University

Program—Tuesday, May 14

"Acid-Base Regulation — Diagnosis and Treatment of Metabolic Acid-Base Disturbances" —**Edmond S. Ricanati, M.D.**

Program—Wednesday, May 15

"Arterial Blood Gas Studies in Health and Disease; their significance in the management of Acute and Chronic Respiratory Failure" —**V. Nath Kapur, M.D.**

Assistant Professor of Medicine at Case Western Reserve University and Associate Physician at Cleveland Metropolitan General Hospital.

COURSE II
"Ischemic Heart Disease"

Course Leader: **Herman K. Hellerstein, M.D.** Associate Professor of Medicine, Case Western Reserve University, Cleveland

Program—Tuesday, May 14

7:30-8:00 a.m. "Angina Pectoris-Facts & Fancy Problems and Diagnosis" (Angina Pectoris in patients with normal arteries. Clinical distribution of subgroups of angina, rationale of treatment with acting nitrates)— **Martin I. Broder, M.D.**
Director of Coronary Care Unit, Cleveland Metropolitan General Hospital; Assistant Professor of Medicine, Case Western Reserve University.

8:00-8:30 a.m. "Exercise Induced Indicators of Insufficiency"—**Wayne Siegel, M.D.**
Head, Cardiac Function Laboratory, Cleveland Clinic Foundation; Department of Clinical Cardiology.

Course II (Contd.)

8:30-9:00 a.m. "Pacing vs. Exercise Induced Angina Pectoris" (Hemodynamics of ischemic left ventricular function. Responses as related to severity of visualized coronary disease)—**Robert C. Bahler, M.D.**
Associate Professor of Medicine, Case Western Reserve University.

Program—Wednesday, May 15

7:30-8:00 a.m. "Natural Course of Surgical and Non-surgical Treatment of Patients with Coronary Artery Disease."—**Earl K. Shirey, M.D.**
Staff Member, Cleveland Clinic Foundation, Department of Cardiovascular Disease and Cardiac Laboratory.

8:00-8:30 a.m. "Management of Acute Coronary Insufficiency" (Merits and limitations of medical and surgical treatment)—**Robert E. Botti, M.D.**
Associate Professor of Medicine, School of Medicine, Case Western Reserve University.

8:30-9:00 a.m. "Surgical Treatment of Ischemic Heart Disease." (1974 Status)—**Jay L. Ankeney, M.D.**
Professor of Surgery, University Hospitals of Cleveland, Lakeside Hospital.

COURSE III
"Principles of Electrocardiography"

Course Leader: **Louis Rakita, M.D.,** Director Division of Cardiology, Cleveland Metropolitan General Hospital, Professor of Medicine, School of Medicine, Case Western Reserve University.

Program—Tuesday, May 14 and Wednesday, May 15

Course Description: Basic Electrophysiology with the Application of Vector Approach to the Interpretation of the Clinical Electrocardiogram.

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COURSE IV
"Concepts of Immunology"

Course Leaders: **Richard C. Graham, Jr., M.D.,** Associate Professor of Medicine; and Assistant Professor of Experimental Pathology, Case Western Reserve University School of Medicine and Head, Division of Infectious Diseases of the Department of Medicine and Assistant Physician of University Hospitals.
Howard J. Schwartz, M.D., Assistant Professor of Medicine, Case Western Reserve University School of Medicine; Head, Division of Allergy, Department of Medicine; and Associate Physician University Hospitals.

Program—Tuesday, May 14

Course Description: Review of Concepts of immunology, biology of the immune response, current concepts on the mechanisms of inflammation and mechanisms of immunological tissue injury and disease.

Program—Wednesday, May 15

Course Description: More specific applications of these principles, dealing especially with (a) clinical immunological lung diseases, and (b) immunology and infectious diseases, including a consideration of defects in normal protective mechanisms.

COURSE V
"Current Concepts in Antibiotic Therapy"

Course Leader: **Phillip I. Lerner, M.D.,** Assistant Department of Medicine, Mt. Sinai Hospital, Cleveland

Program—Tuesday, May 14

7:30-8:15 a.m. "Principles of Antibiotic Usage"

8:15-9:00 a.m. "Laboratory Aids in the Diagnosis of Infection"

Program—Wednesday, May 15

7:30-9:00 a.m.—"Discussion of New Antibiotics"

COURSE VI
"Radioactive Scans and their Application"

Course Leader: **Antonio Rodriguez-Antunez, M.D.,** Director, Department of Radiation Therapy and Nuclear Radiology, Cleveland Clinic Foundation.

Program—Tuesday, May 14

Note: Entire program presented by the Department of Radiation Therapy and Nuclear Radiology, Cleveland Clinic Foundation.

7:30-8:00 a.m. "Clinical Application of Thyroid and Pancreatic Scan"—**A. R. Antunez, M.D.**

8:00-8:30 a.m. "Clinical Application of Brain and Kidney Scans"—**Thomas W. Hunter, M.D.**

8:30-9:00 a.m. "Clinical Application of Liver Scans"—**G. Jelden, M.D.**

Program—Wednesday, May 15

7:30-8:00 a.m. "Clinical Applications of Bone Scan"—**R. Balsys, M.D.**

8:00-8:30 a.m. "Clinical Application of Lung Scan"—**G. Jeldin, M.D.**

8:30-9:00 a.m. "Clinical Application of Dynamic Flow Studies"—**W. MacIntyre, Ph.D.**

Critical Care Symposium — pulmonary function and blood gas changes in critically ill and injured patients, April 18-20, 1974; sponsored by the Department of Surgery, Wayne State University — held at the Wayne County Medical Society Headquarters, 1010 Antietam, Detroit, Michigan, 48226; fee $75 for practicing physicians; $40 for residents, nurses, and inhalation therapists. For further information and registration, call 313/961-7302, extension 546.

MINORITY REPORT

TO THE

REPORT OF THE

GOVERNOR'S TASK FORCE ON HEALTH

William R. Schultz, M.D.

Representing The
Ohio State Medical Association

and

Peter Lancione, M.D.

Editor's Note: The Governor's Task Force on Health was appointed by Governor John Gilligan in early March, 1973, to examine aspects of health care in Ohio. Sixty-five Ohio citizens were named to the task force, of whom 12 were physicians (M.D.'s and D.O.'s). The group met several times and finally issued its report in December, 1973.

The full report has been well publicized, while the minority report has gotten comparatively little public exposure. For that reason, it is being published in its entirety here for the information of Ohio physicians.

For the benefit of those readers who have not seen the majority report, copies will be available soon from the Ohio Department of Health.

In 1846 the Ohio State Medical Association was formed to provide a mechanism to assist Ohio's physicians in the provision of the best possible medical care to the people of Ohio. Since that time, Ohio's physicians have worked diligently toward that goal, on both scientific and socio-economic fronts.

The organized profession, on state and local levels, has been instrumental in encouraging such concepts as single and multi-specialty group practices, foundations, peer review and fee review mechanisms.

Many local societies operate reference services to help the public find a primary care physician. The state association and many local societies have for many years sponsored family practice scholarships and loan guarantee programs to assure that a competent medical student will receive proper medical education regardless of sex, race, or ethnic background.

The Governor's Task Force report has developed numerous recommendations to provide a new and untested health care strategy for the state. These recommendations seem based upon a selected group of findings and statistics, very few of which reflect the activities of medicine today or during the last century. The role of the physician is minimized or overlooked in most areas of the report.

In attempting to provide increased access to medical care, the report concentrates on reorganization, restructuring, and the careless obliteration of successful, functioning programs for the sake of producing something new. It does not deal with individuals and physicians and, in fact, encourages the state to curtail current plans to produce more Ohio physicians for Ohioans. Access to medical care can come only through physicians--there is no other way. Institutions and organizations do not and cannot provide medical care. Only a properly educated and properly motivated physician can do this.

In an effort to maintain brevity, only a few specifics within the Governor's Task Force report have been chosen for comment. This should not be interpreted as meaning that the feelings of Ohio's physicians do not run strongly on other issues.

UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

The Ohio State Medical Association House of Delegates, in 1967, passed a resolution (9-67) advocating the "construction of additional medical schools in Ohio by June 1, 1969." As a result of this, Ohio's physicians officially disagree with the Governor's Task Force recommendation that new medical schools, already approved and funded by the state legislature, not be established at the present.

Graduate medical education in primary care fields (e.g. -family practice residency programs) is one aspect of the report that can be heartily endorsed. As early as 1947, The Council of the OSMA advocated establishment of such residency programs and has been encouraging them ever since. It is important to note, however, that in order for such residency programs to be successful, there must be an effort made in undergraduate medical education to produce additional students and to promote primary care as a desirable field of practice. Residency programs without residents are meaningless.

EMERGENCY MEDICAL SERVICES

Increasing access to emergency care has been a goal of organized medicine for many years. Early activities centered around civil defense procedures, but in 1961, the Ohio State Medical Association restructured its committee activities to include a Disaster Medical Care Committee (now called Emergency and Disaster Medical Care). This group has promoted state-wide and local training programs and has been instrumental in placing adequate communication equipment. (High cost factors often stand in the way of this committee's standards and goals.)

During the last few years, the OSMA was developing a state-wide Emergency Coordinating Council (called for in the Governor's Task Force report) but was asked instead to participate in a council being formed by the Ohio Department of Health.

The OSMA was told that the ODH was going to place greater emphasis upon Emergency Health Care Delivery and that added staff time and additional funding was forthcoming. As a matter of fact, since the OSMA was asked to reduce its efforts, the ODH has reduced, not increased, staff efforts in this area and has not arranged for any additional funding.

The net result of this situation is that the total emergency care system in Ohio has suffered a setback because of governmental intervention and failure to do that which it promised it would do.

The recommendations called for in the Governor's Task Force report to promote emergency care for Ohioans are very worthy, but implementation is the only real way to carry out these goals and the ODH has not, to date, seen fit to provide implementation.

MEDICAL PRACTICES ALTERNATIVES--HOSPITAL PRACTICE OF MEDICINE

The Governor's Task Force report makes a variety of general remarks leading to the conclusion that the prepaid practice concept is the panacea for assuring access to medical care while reducing costs. The medical profession in Ohio has long advocated that a variety of alternative methods of providing medical care should be investigated, but to subsidize any one system so that it will appear to provide better access or lower costs would be unfair and, in fact, could be detrimental to the health of Ohioans, and the state would be in the position of choosing for the patient his physician and his health care system.

The report states that the State of Ohio should establish a goal of one million participants in prepaid practice arrangements by 1980 and calls for state funding to accomplish this goal. To promote any type of medical practice to the relative economic detriment of another system does not appear to be a legitimate use of state tax funding and should not be permitted. Prepaid plans--groups and foundations--must be allowed to grow within the supply and demand system because they are needed and useful, not because they receive artificial heavy governmental subsidy and could result in a distorted record of cost and efficiency.

The Governor's Task Force report also states that hospitals, using state funds if necessary, should provide medical services where such services do not now exist. Hospitals cannot practice medicine--only a physician is capable of that action. If the Governor's Task Force report writers meant that local hospitals should develop an atmosphere conducive to encouraging new physicians into an area of need (an idea stated by the OSMA over 50 years ago) then that should have been more clearly stated. An institution cannot practice medicine.

HEALTH DEPARTMENT REORGANIZATION

Although there has long been a feeling among Ohio's physicians that there should be some streamlining of local health districts, the Governor's Task Force has called for a complete change in the concept of providing public health in Ohio.

The report calls for a structure built from the top down, displacing many capable individuals and removing all local self-rule.

No longer will township trustees and county commissioners have any responsibility for or knowledge of local health issues. All communications and planning would be handed down from the state level. The potential hazard here, of course, is that should the state fail in any way to carry out its duties, either because it lacks adequate personnel and/or funds, the local people would be powerless to withstand such public health hazards as major epidemics, to provide proper testing and screening, or to help with public health education.

This type of reorganization is typical of the general trend toward centralized authoritarian governmental control which is characteristic of the entire report.

CERTIFICATION OF NEED

Organized medicine feels that the theory behind local certification of need is a sound one: care must be taken so that health care dollars are spent in a sound, economic manner. This theory has been broadened by the Governor's Task Force report, however, to include every conceivable type of health care provider, as well as various types of equipment and institutions.

The Governor's Task Force report should be greatly modified so that the concept of certification of need is applied only to bricks and mortar, not services. Applying the concept to individual citizens as the report does, borders on the philosophy of totalitarianism, "the individual exists for the state."

PROFESSIONAL BOARD REORGANIZED - LAY MEMBERS

Portions of the Governor's Task Force report deal with a total reorganization of the various boards of state government that license health professionals. The very essense of these boards is to provide public protection and accountability and Ohio's physicians find it totally inconceivable that a lay individual might be able to serve on the State Medical Board to assist in providing this protection.

Medical judgments and professional decisions cannot be made by individuals not trained in medicine. Lay people should not dilute the various boards just because consumerism is the current vogue. Recourse through the courts provides non-medical review.

MEDICAL MALPRACTICE AND PATIENT GRIEVANCE

Some specific comments on the legal aspects of malpractice:

(A) The application of the "discovery" rule in medical malpractice cases. The "discovery" rule is already applied in medical malpractice cases involving foreign objects (e.g., a sponge not removed during a surgical procedure). Melnyc v. Cleveland Clinic, 32 Ohio St. 2d 198, the application of the "discovery" rule in such cases as those involving foreign objects may be justified but there is no justification for extending the rule to any and all malpractice cases.

Interesting enough, the discovery rule is not even applied in Ohio in malpractice cases involving attorneys. Keaton v. Kolby, 27 Ohio St. 2d 234. Thus, acceptance of the Governor's Task Force recommendation of "equal treatment" would lead to the rejection of the "discovery" rule in all malpractice cases. In any event, it is clear that the "discovery" rule is already being applied in Ohio and that no further extension of the rule is necessary or desirable to protect the legitimate interests of the patient.

(B) The term of the statute of limitations. The Ohio statute of limitations provides that malpractice action shall be brought within one year. (R.C. 2305.11). This statute of limitation applies not only to physicians but also to attorneys and other professionals. In short, the statute of limitations is being applied under present law equally to all classes of professionals and there is no justification or merit in suggesting that the term of the statute of limitations applicable to physicians should be different from that applied other professionals.

(C) Application of the res ipsa loquitur doctrine to damages arising and the performance of professional services. The Ohio Supreme Court recently reviewed thoroughly the many arguments pro and con relating to the application of the res ipsa loquitur doctrine to medical malpractice cases. Oberlin v. Freidman, 5 Ohio St. 2d 1.

After its review the Ohio Supreme Court formulated the following rule:

> "Generally, the doctrine of res ipsa loquitur is not applicable in (medical) practice actions in which its claimed applicability is based solely upon the fact that the treatment was unsuccessful or terminated with poor or unfortunate results."

The rule of law in Ohio regarding the application of the res ipsa loquitur doctrine is fair to both the physician and the patient and that Task Force has demonstrated no basis in fact or in law to support any change of the present application of the rule.

(D) Doctrine of informed consent. The Governor's Task Force recommendation regarding informed consent is unnecessary. The law already recognizes that the physician has a legal duty to inform his patient of the risks of proposed medical treatment, its potential side effects, etc., but also recognizes that such a duty is not an absolute one and that, in situations where the explanation itself may have an adverse medical effect on the patient, the disclosure or explanation may be modified under the circumstances of a particular case. Again, the present law is sufficiently fair and flexible to meet the legitimate interests of both physician and patient.

The Task Force recommendation that legislation be enacted to prohibit modification, alteration or destruction of medical records with the intent of misleading or misinforming the patient is outrageous. Present laws relating to fraud, destruction of evidence and obstruction of justice amply protect any litigant who relies upon records to prove his claim, not only those who choose to sue their physician. To suggest legislation relating solely to medical records is discriminatory and implies that there is a serious problem which must be remedied by special legislation. No evidence of such a problem was given in the Task Force report and to recommend such a drastic legislative insult aimed solely at the medical and health care professions in the absence of such supporting evidence constitutes an unfortunate attack upon the integrity of all medical and health care professionals and suggests promotion of poor legislative practices.

QUALITY ASSURANCE

One of the important facets of the Governor's Task Force report was to provide adequate accountability of health providers to assure quality. The report written made no reference to important work in this area by Ohio's physicians.

Medical Advances Institute Peer Review Systems, pioneered by the Ohio State Medical Association, has been developed by doctors to review doctors. It has been organized by physicians to supply a peer review system that works and provides meaningful impact to assure quality. The review "system" asked for by the report is political review, not peer review.

Peer review, to assure that Ohio's people receive the best quality medical care, is a worthy goal, one that medical professionals have worked for in Ohio since the last century.

COST CONTAINMENT

One of the most interesting health cost statistics of the past few years was overlooked by the staff of the Governor's Task Force. Costs of health care have risen in direct proportion to the involvment of both federal and state governments during the past 25 years. The medical profession predicted these results.

Increased costs of operation of health care facilities, caused by more and more reporting and paperwork requested by government, must be reflected in higher costs to patients. After all, whether payment for medical services are by prepaid practice, third party reimbursement, governmental programs or private pay, costs for medical care will eventually be passed directly to the public. There is no other way.

Increased programs result in increased cost and no amount of restructuring can change that basic principle. The chaotic condition of Ohio's Medicaid program illustrates "government medicine."

BLUE CROSS/BLUE SHIELD

The takeover of Blue Cross and phasing out of Blue Shield is called for in the report. Ohio's Blue Cross/Blue Shield non-profit organizations provide unexcelled service to the people of Ohio and have returned a higher percentage of the premium dollar for benefits than other third party plans. If the state expropriates Blue Cross and turns it into another state agency (Will it be more efficient than

the Welfare Department?) it will have no incentive to continue to cooperate with Blue Shield plans; in fact, it would be adverse to do so. State government would thereby remove current provider input to reimbursement procedures. Thus the state would take over the vast majority of funding for total health care in Ohio. When this sort of thing happens to an oil company in South America, it's called "nationalization" and is decried by most clear-thinking Americans.

REPEAL OF ANTI-SUBSTITUTION

The goal of the Governor's Task Force report is to provide better quality of health care for Ohioans. The reverse of that will be true if the Task Force recommendation on repeal of drug anti-substitution laws were to be adopted. Quality of care will be in great jeopardy because there will be substitution not only of the drug, but also substitution of the physician's professional judgment; or, worse yet, in the case of a state-wide formulary, the judgment of a committee of state employees. Neither the formulary not the pharmacist can take into account the patient's medical history or current physicial condition.

Repeal of anti-substitution laws coupled with a state-wide formulary would tie the hands of Ohio's physicians and would prohibit them from exercising their best professional judgment.

Generic prescribing is a very hazardous practice because the practitioner has no way of being assured that the drug selected for dispensing by the pharmacist is of the same high quality as the specific medication selected by the doctor.

Generically may be quite different acting, especially in combination, because of quality control factors at the point of manufacture. A lump of coal and a diamond have the same generic formula. Are they the same?

CHIROPRACTIC

One of the most disturbing aspects of the Governor's Task Force report is that, while the report goes on and on at great length discussing increasing the quality of care received by Ohio's people, there was not a single comment made about one of the greatest problems the state needs to face vis-a-vis quality care: Lack of protection against chiropractic.

Chiropractic is an unscientific movement that purports to produce "healing" through manipulation (subluxation) of the spine. It has been decried by federal agencies, labor unions, medical associations and even by other Governor's state health task forces (a copy of the Wisconsin study of Chiropractic [was] attached as an appendix to [the original] report).

The staff writers of this Task Froce report did not see the problem as meriting consideration by the Quality Committee or by the full Task Force. The report concentrates on rearrangement of Ohio's health care system and health professionals but does not meet quality problems head on.

SUMMARY

In summary, it appears that the staff writers of the Governor's Task Force report equate long lines, huge waiting rooms and impersonal care with quality medicine. Many ideas which would result in better quality and better access are touched upon briefly or not at all: such items as production of more primary care physicians; control of chiropractors and others who prey upon misunderstanding on the part of the public; protection of the physician-patient relationship from outside interference; and the provision for adequate and acceptable peer, utilization, and fee review.

As with all other costs, and taxes, costs for health care have risen in the last few decades, but so has the quality of health care. Vital equipment and personnel are available now that were not here even ten years ago, and their costs are reflected in the total health care picture.

Increasing demands by government for accountability have also increased costs. The public must some day make its decision concerning health costs; does it want the best possible medical care or

does it want a rigid, cost accounting system.

In addition, people must learn that adequate health maintenance is not something that the health care system or big government can provide. It's an individual thing. As long as Americans continue to smoke and drink and overeat and refuse to adequately care for themselves by proper exercise, diet, education, and employment, the health factor of this nation cannot improve.

True health maintenance is personal, not institutional, and no amount of mass governmental spending is going to make up for that personal factor.

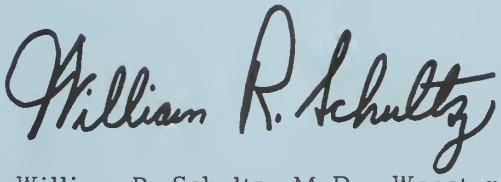
In short, gross reorganization without allowing for interpersonal relationships will not result in increased quality or access of medical care. This report, if implemented, would result in an all-powerful Director of Health controlling the personal aspects of health in Ohio.

The state would decide who would practice what types of medicine and where. The state would control access to health care by controlling the location and number of health related technicians and their equipment. The state would select appropriate practitioners for the public by promoting prepaid practices. The state would control reimbursements to almost all health care providers by taking over Blue Cross, doing away with Blue Shield, and continuing to operate such programs as Medicaid.

In reality, government would then be in the business of providing health care to Ohioans. Past experiences indicate that when government takes such controls, costs go up and quality goes down, the opposite of the goal for which the Task Force originally gathered.

Ohio's physicians believe that access should be strengthened and quality should be guaranteed, but not through the type of governmental intervention advocated by this report.

The free and independent people of the State of Ohio will not tolerate a medical and health czar and this concept's effect on their personal lives.



William R. Schultz, M.D., Wooster, Ohio
Member, Governor's Task Force on Health
(Representing the Ohio State Medical Assoc.)



Peter Lancione, M.D., Bellaire, Ohio
Member, Governor's Task Force on Health

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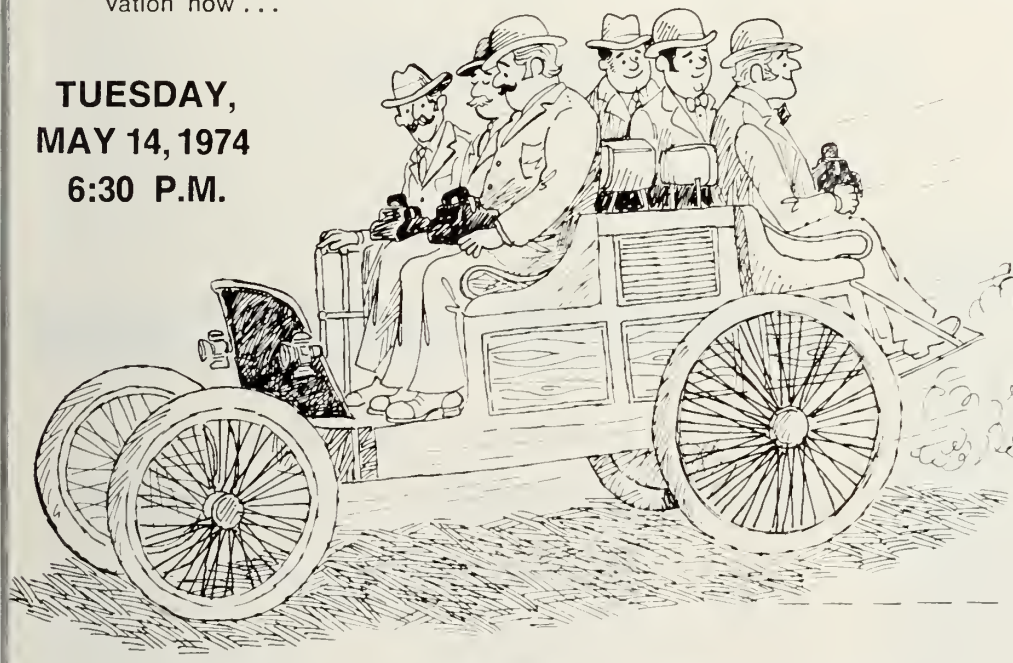
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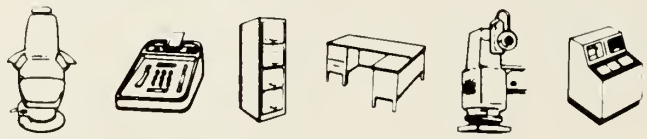
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Wednesday, May 15, 1974

Program sponsored by the Ohio State Medical Sections on Pediatrics, Physical Medicine and Rehabilitation, and Sports Medicine with the cooperation of the President's Council of Physical Fitness.

Morning Program

Moderator: **Claire Wolfe, M.D.,** Clinical Assistant Professor, Department of Physical Medicine & Rehabilitation, Ohio State University

9:00 a.m. Introductory Remarks

9:10 a.m. **"Physiology of Running" — David Costill, Ph.D.,** Professor and Director, Laboratory for Human Performance, Ball State University, Muncie, Indiana

9:35 a.m. **"Exercise for Men" — Lawrence Golding, Ph.D.,** Kent State University

10:00 a.m. Coffee Break

10:30 a.m. **"Exercise and Training in Women" — Edward L. Fox, Ph.D.,** Professor of Health Physical Education & Recreation, Ohio State University

10:55 a.m. **"Family & Community Program of Physical Fitness" — Richard Keelor,** President's Council on Physical Fitness, Washington, D.C.

11:20 a.m. Questions and Answers Period

11:30 a.m. **"Physical Fitness" — Jesse Owens,** Phoenix, Arizona

12:00 Noon Break for Lunch

Afternoon Program
"For Those Who Must Run Slowly"

Moderator: **H. Royer Collins, M.D.,** Orthopedic Department, Cleveland Clinic

1:00 p.m. **"Exercise Testing for Cardiac Disease" — Wayne Siegle, M.D.,** Internal Medicine, Cleveland Clinic

1:30 p.m. **"Post-Coronary Rehabilitation" — Charles Long, M.D.,** Physical Medicine and Rehabilitation, Highland View Hospital

2:00 p.m. **"The Physically and Mentally Handicapped" — Walter F. Ersing, Ph.D.,** Associate Professor Health, Physical Education and Recreation, Ohio State University

2:20 p.m. Questions and Answers Period

2:30 p.m. Coffee Break

3:00 p.m. **"Overuse Syndromes" — John Bergfeld, M.D.,** Orthopedic Department, Cleveland Clinic

3:20 p.m. **"Knee Problems in Running Sports" — Kenneth De Haven, M.D.,** Orthopedic Department, Cleveland Clinic

3:40 p.m. **Panel of Potpourri**
John Bergfeld, M.D., Cleveland Clinic; **Kenneth DeHaven, M.D.,** Cleveland Clinic; **Victor Ippolito, M.D.,** Team Physician of Cleveland Browns; **Robert Mack, M.D.,** Head of Sports Medicine Department, Case Western Reserve University; **Robert Mercer, M.D.,** Pediatric Department, Cleveland Clinic; **Melvin Olix, M.D.,** Team Physician, Athletic Department, Ohio State University; **Richard Slager, M.D.,** Orthopedic Surgeon, Ohio State University

Art Show Planned

FOR 1974 OSMA ANNUAL MEETING

Space will be provided at the 1974 Annual Meeting of the Ohio State Medical Association, Monday, May 12th through Wednesday, May 15th for a Physicians' Art Show. The Art Committee of the Academy of Medicine of Cleveland will merge their efforts with those of the Committee on Scientific Work of the Ohio State Medical Association, for the creation of a magnificent Art Show at the annual meeting.

Members of the OSMA, their wives (or husbands), who are interested in exhibiting pieces of art work (they personally have created) or who require information concerning the exhibit, should fill out the application included below *without delay.*

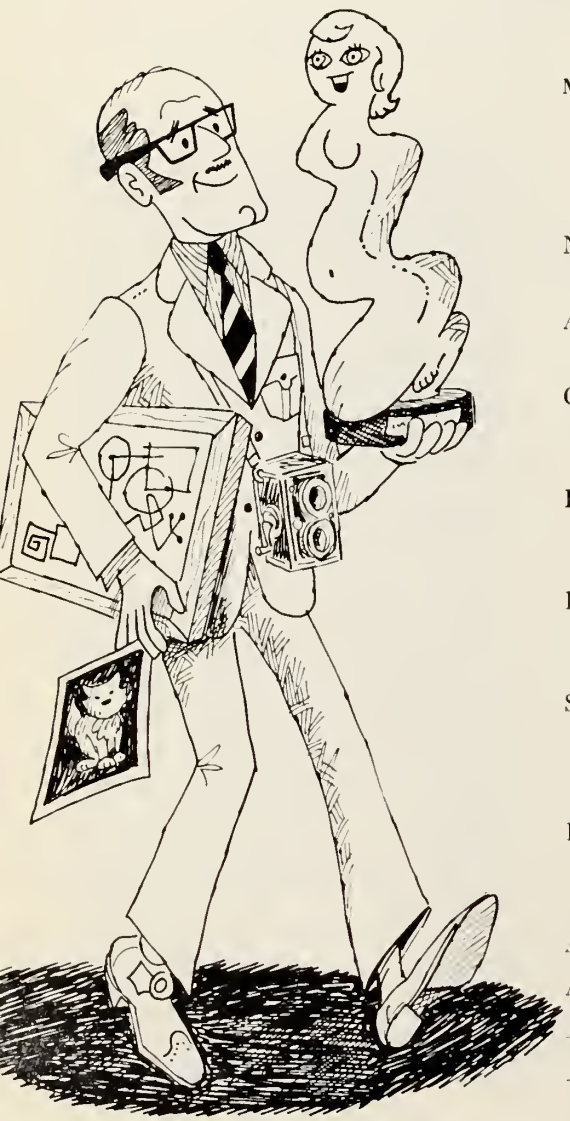
It will be the responsibility of each exhibitor to see that his work gets to the exhibit area, on the balcony of the Exhibit Hall, in the Sheraton-Cleveland Hotel, NO SHIPMENTS WILL BE ACCEPTED. Time to receive such deliveries: Monday, May 13th from 8:00 a.m. to 4:00 p.m. (the earlier the better). No exhibits can be accepted after 4:00 p.m. on Monday, 13th (except by very special arrangements).

Each exhibitor will be responsible for transportation costs, insurance and other expenses involved in entering his or her exhibit. Guards will be provided for protection.

Exhibitors will be limited to two art pieces per category. Categories will be (1) Paintings (watercolor); (2) Paintings (oil) and (acrylics); (3) Sculpture; (4) Photo-Arts; and (5) Crafts.

An independent Art Award Committee will judge the exhibit competitively—ribbons will be awarded.

We solicit your exhibits and hope you will assist us to make the 1974 Art Show an outstanding success.



Application for Space in 1974 OSMA Art Show Exhibit

Mail to: **Victor C. Laughlin, M.D., Chairman**
1974 OSMA Art Show Committee
Academy of Medicine of Cleveland
10525 Carnegie Avenue
Cleveland, Ohio 44106

Name_____

Address_____

City_____ Zip Code_____

		Title	Dimensions	Value*
Paintings (watercolor)	1.			
	2.			
Paintings (oil & acrylics)	1.			
	2.			
Sculpture (pedestal— or wall type—	1.			
	2.			
Photo-Arts (mounted, ready to hang)	1.			
	2.			

Additional information desired or which you believe will be helpful to the Art Show Committee. _____

(*Please include a fair market value for insurance)

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OSMA Annual Meeting Promotion Brochure Win Top Honors

The Ohio State Medical Association has received numerous compliments on its Annual Meetings and on the thorough preparations that precede these meetings. The latest honor received by planners of the Annual Meeting came at the recent Dallas Texas meeting of the Professional Convention Management Association, a national organization comprised of associations in the medical, dental, hospital and allied professional fields.

The Ohio State Medical Association won top honors in the "Award Winning Exhibit Prospectus," for its brochure sent out in advance to prospective exhibitors at the 1974 Annual Meeting scheduled in Cleveland.

The brochure was judged on the basis of its completeness, clarity of information contained and general adherence to the guidelines covering information to be included in any prospectus. The prospectus was judged by a panel of persons who received the mailing piece.

Maternal Health Committee Celebrates 20th Anniversary

The Committee on Maternal Health, appointed by the President under provisions of the resolution adopted by the House of Delegates of the Ohio State Medical Association on April 23, 1953, held its first meeting at the Columbus office on Sunday, January 10, 1954. The Committee held its 20th Annual Meeting in Granville on January 19 and 20, 1974.

The Committee has been under the leadership of Dr. Anthony "Jim" Ruppersberg of Columbus for 20 years.

The Committee's function has been to study, analyze and report on all maternal deaths in Ohio. The Committee has carried out this function in a dedicated and professional manner. More than 1700 cases have been taken into consideration in the 20 years of being in operation. In addition to this project, the Committee has contributed many scientific articles on maternal mortality studies in *The Ohio State Medical Journal* as well as scientific exhibits at Ohio State Medical Association Annual Meetings.

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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964



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Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

ONCE UPON A TIME two young doctors' wives who had not yet joined the Woman's Auxiliary to the Cuyahoga County Medical Society met at the state convention at Cleveland's Hotel Statler. They had come to "help out," answering an appeal by the auxiliary for typists and other needed services. They felt like lost souls, knowing hardly anybody, and then they found each other that day and suddenly everything was fine. That was in 1956—and in that same year they became auxiliary members.

Who are they? Allow me to present this year's convention chairman and co-chairman—Mrs. Thomas L. Manning and Mrs. F. M. Freimann. It's a natural—this teaming up not only of two good friends but of two dedicated and outstanding auxiliary members who have served Cuyahoga county well and the state organization equally so (both serve on the state board).

Jeanne Manning holds an undergraduate degree in music and a Master's in social work and she has stayed "with it"—serving on the boards of the Catholic Child Guidance Clinic and Children's Services, and giving one day a week to retarded children in a swim program. She's also an active member of the Woman's Committee of John Carroll University and the St. Alexis Hospital Woman's Guild. And she's still the talented pianist—accompanying performers at the Cleveland Institute of Music and playing for fashion shows, etc.

Interestingly, Petey Freimann became an auxiliary member in the same year she became a United States citizen. She was born, educated and married in Hungary but fled the country with her husband in 1944 (emigrated to the U. S. in 1951). This is the same Petey Freimann who, as auxiliary state safety chairman in 1973, actually succeeded in getting the State of Ohio to correct a highway traffic sign that was misleading!

Convention Highlights

The dates are May 13, 14 and 15 — the place, Cleveland; the hotel, Woman's Auxiliary headquarters, the Statler Hilton. May 13 is the state preconvention board meeting; May 14 and 15 the convention itself. And it promises to be an exciting one. Fuller details will be given in the April issue of *The Journal* particularly as they concern the House of Delegates and the business sessions. But here's a bit of a bird's-eye view of the social calendar:

There will be a special tour on Tuesday afternoon, May 14th, which will include the most beautiful buildings in Cleveland and their surroundings. "I can think of no lovelier spot anywhere than the Garden Center in May and it is here that we shall end our afternoon tour with a Tea," Mrs. Manning advises me. "Yet we shall be back to the hotel in time for the reception to be given by the auxiliary's president and president-elect."

Tuesday night will witness a gala dinner-dance sponsored by the Ohio State Medical Association at Cleveland's charming and intriguing Crawford Auto Museum. On Wednesday, Cuyahoga County's Gavel Club will host a delightful luncheon at Cabaret, one of the most successful and scintillating theatre-restaurants in the newly revitalized Playhouse Square. Entertainment at the luncheon will feature musical selections by a professional cast, the members of which have received rave reviews from Cleveland's newspaper critics.

In last month's issue of *The Journal* I mentioned "The County Special." It is to be presented Wednesday morning at the Convention Breakfast. It will be the county reports in somewhat different "dress" — simulating a television panel show with all the proper "effects," even unto an honest-to-goodness television camera!

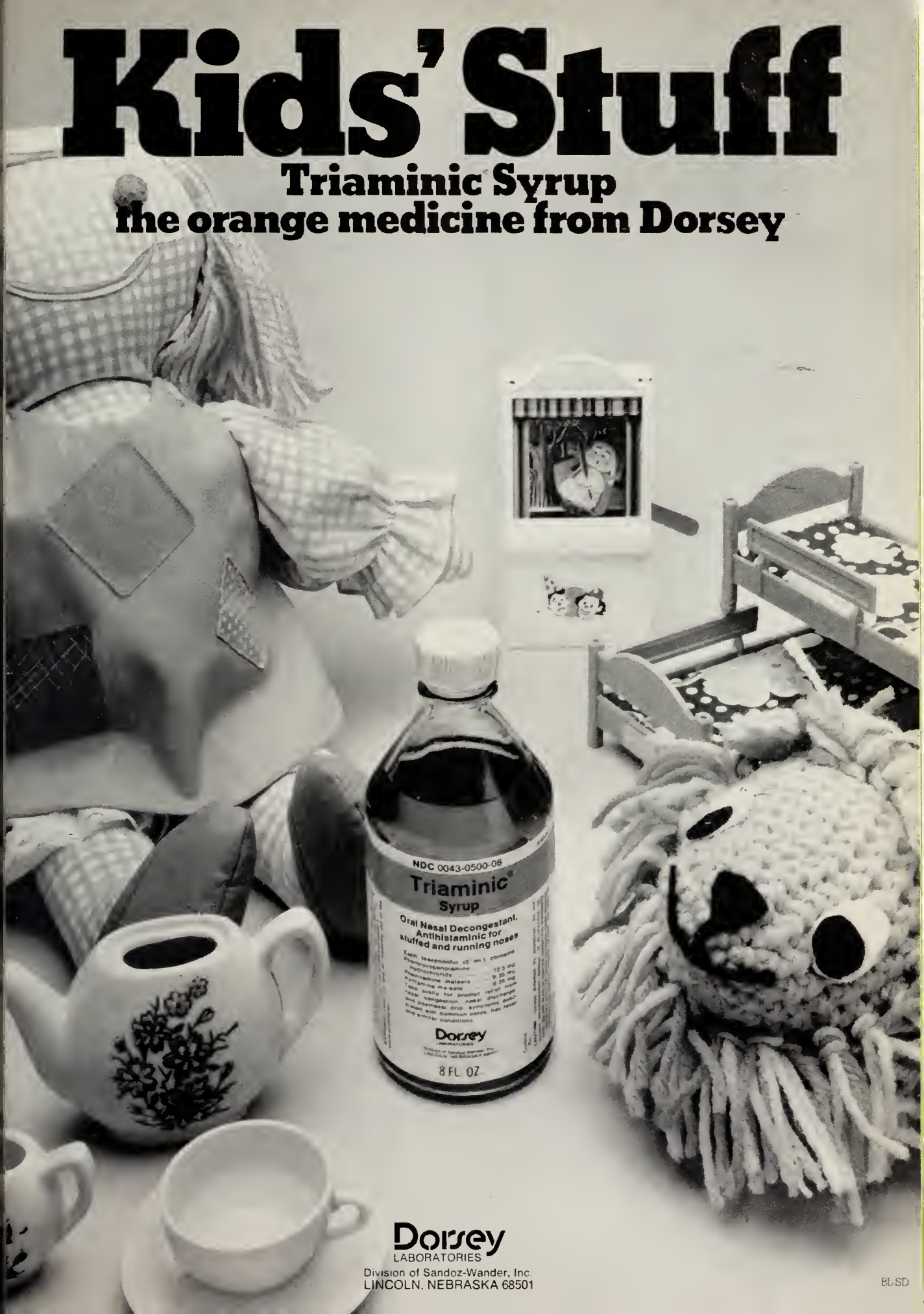
Day at the Legislature

It was so much of a success last year that Mrs. S. Baird Pfahl, state legislation chairman, is planning it again — a meaningful Day at the Legislature. It is a tremendous opportunity to see your legislators in action and to have the opportunity to meet with them at luncheon. Here's the way the program is set up for *Tuesday, March 26:*

> 9:30 a.m. — meet at the OSMA office for general orientation — to learn of bills to be heard in session that day and bills medically related that OSMA would like the auxiliary members attending to talk to their legislators about — David Rader, OSMA lobbyist, will

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lead the discussion.

Attend House session and or committee hearings.

12:00 noon — meet for luncheon at the Sheraton-Columbus with the members' own legislators. Cost of the luncheon — seven dollars (approximately).

Following luncheon, return to OSMA for discussion of the experience and all state medical-related bills.

Mrs. Pfahl urges every county auxiliary to bring at least one car full! She asks that the county president-elect, legislation chairman and "legsline" members particularly attend. It's much too good an opportunity for anybody to miss!

Information Please?

The auxiliary's indefatigable state legislation chairman, whom I have just mentioned, Fifi Pfahl, has recently sent out to legislation chairmen throughout Ohio a terrific "Legislative Bulletin" that covers everything from books, trends, summary of major NHI proposals in Congress to the status of other Health Legislation in Congress and the summary of the status of State Health Legislation. Mrs. Pfahl must have spent days and days and days (weeks? months?) pouring over tons of material to produce so expertise and detailed a summary!

A new book mentioned in this bulletin is *The Dance of Legislation* by Eric Redman. It was reviewed in the *American Medical News* December 3, 1973: "The story is of special interest to physicians because it deals with the bill that created the National Health Service Corps (NHSC) as it wound its way through Congress in 1970, as told by the author in one of the most unusual popular books of the year.

"The NHSC is the program that sends public health physicians to physician-short areas for a two-year hitch in hopes they might like it and settle down in the particular area. There are more than 200 physicians now serving in remote rural districts and in some inner-city locations."

Important

Because of increasing printing costs and decreasing advertising revenues, OSMA officers have found it necessary to limit the Auxiliary's space in *The Journal*, along with similar restrictions on other features. For the time being, space allotment is one page per issue. Hopefully, pharmaceutical manufacturers and other supply houses will funnel more of their advertising into the State Journal, and space will be increased proportionately. For now, this means curtailed use of county activities. Sorry!

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Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products and let them know that you see their advertising in *The Journal*.

In This Issue:

Abbott Laboratories 161

Air Force Opportunities 143

Allergy Laboratories of Ohio 158

The Brown Pharmaceutical Co., Inc. 154, 194, 198

Burroughs Wellcome Co. 184

Capital Financial Services 194

Dorsey Laboratories, Div. of Sandoz-Wander, Inc. 147, 197, 201

Flint Laboratories, Div. of Travenol Lab., Inc. 150-151

Immke Circle Leasing 148

Lilly, Eli and Company 164

McNeil Laboratories 157

Mead Johnson Laboratories 159

The Medical Protective Co. 154

Ohio Medical Indemnity, Inc. 199

Pharmaceutical Manufacturers Association 162-163

Roche Laboratories, Div. of Hoffman-LaRoche, Inc. .....Inside Front Cover-141, Inside Back Cover-Back Cover

Wm. H. Rorer, Inc. 155

G. D. Searle & Co. Medical Department ..182-183

Smith Kline & French Laboratories Division of SmithKline Corp. 181

The Upjohn Company 144-145

Wendt-Bristol Co. 152

Windsor Hospital 153

Wolman Insurance Agency, Inc. 188

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Box (insert number), c/o The Ohio State Medical Journal
17 South High Street, Suite 500, Columbus, Ohio 43215

PHYSICIAN'S OFFICE FOR RENT in Mariemont, a Village adjacent to Cincinnati, near a good hospital. Contact L. Hermanies, 3900 Oak St., Mariemont, Ohio. Phone 271-0291.

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INTERNIST AND PEDIATRICIAN WANTED—Incorporated group of three general surgeons and one obstetrician-gynecologist looking for board qualified or certified internist and pediatrician. We are located in north central Wisconsin serving a community of approximately 25,000 with a summer population of 200,000. We have excellent recreational and educational facilities including college. Anyone interested write to Dr. I. E. Schiek Jr. or Dr. Otto G. Rosemeyer c/o The Schiek Clinic S.C., Rhinelander, Wisconsin 54501 or call collect 715/362-6160.

EMERGENCY ROOM PHYSICIAN to work in 250 bed hospital with new Emergency Room. Excellent facilities and working conditions. Salary $40,000 annually for working every 4th day with excellent fringe benefit package. Hospital located 40 miles north of Columbus, Ohio. Contact David G. Paff, M.D., 399 East Church Street, Marion, Ohio 43302. Phone: 614/382-1133.

FOR RENT: SANIBEL CONDOMINIUM, new two bedroom, Gulf beach front condominium with pool and tennis courts, Sanibel, Florida. Reply Box 697, c/o Ohio State Medical Journal.

FOR RENT — Medical Office Space, 350 square feet, excellent location. 303 E. Town street, Columbus, Ohio 43215. Available March 1, 1974. Call Paul Richards, M.D. 614/464-0232.

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Dr. Ruben Meyer, Director of MCH Program
Dr. Arthur Fleming, Director of Graduate Program for Physicians in Mental Retardation and Related Disabilities

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(Continued from Previous Page)

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CALLAWAY GARDENS, GA. — FOR RENT, 7 room A-Frame, sleeps 8, beautiful family resort, many activities including 63 holes golf. $175.00/week. Reply Box 701 c/o Ohio State Medical Journal.

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

VOLUME 70 APRIL 1974 NUMBER 4

Original Articles

Intestinal Cancer in the Peutz-Jeghers Syndrome. A Re-evaluation. John D. Reid, M.D., and Mary Petrelli, M.B., Cleveland 231

Papillary Cystadenocarcinoma of the Pancreas. Joseph L. Bilton, M.D.; Nadir D. Saddawi, M.D.; Krishna P. Saigal, M.D.; and Madhira D. Ram, M.D., Cleveland 236

The Nontoxic Edema of Pregnancy. Melvern A. Ayers, M.D., Toledo 239

Your State Society at Work

A Message from the President: The Cost of Getting the Job Done 241
OSMA Budget for 1974 282
New Members of the Association 285
Two More Students Sought for OSMA Family Practice Scholarship 246

1974 OSMA Annual Meeting

Annual Meeting Clinical and Scientific Features:
Vascular Diseases from Infancy to Old Age .. 252
Chest Physicians 253
Heart and Lung Day 253
Interrelationship of ENT, Allergy and GP-FP 254
Communication Between Doctor and Patient 254
Physical Medicine and Rehabilitation 255
Does Your Office Have an Energy Crisis? .. 255
ENT and Occupational Medicine 256
Ophthalmology 256
Neurological Surgery 256
The Present and Future of Neurological Practice 257
Problems and Questions Re Early Emergency Care and Emergency Departments 258
Plastic Surgery 258
Recent Advances in Psychological Approach 263

Other Annual Meeting Features
Art Show 264
OSMA's Olde But Goode Night 266
OMPAC Luncheon Reservation Form 266
Make Your Hotel Reservations 251

The House of Delegates, 1974 Sessions:
Candidate for the Office of President-Elect .. 243
OSMA House of Delegates Agenda 267
Reference Committees of the House 268
Final Session Agenda 269
1974 Members of the House of Delegates 270
Resolutions Submitted for Consideration 277

Insurance Claim Forms

AMA-Sponsored Uniform Claim Form for Accident and Health Insurance 215

Public Health

Community Health News: Influenza and Reye's Syndrome; Hemophilia 219

Specialized Programs

Traveling Newborn Workshop Open to Ohio Physicians 212

Working with the Agencies

What Is SSI (Title XVI) All About? 208

Keeping Up

Continuing Medical Education for Physicians in Ohio 226

Woman's Auxiliary

Highlights: Going My Way to Cleveland 284

Other Features

Executive Director Named by Columbus Academy 281
Federal Funds Again Requested by OSU 281
Opinion of Attorney General, Re DOA Patient .. 206
Lions Eye Research Funds 285
Traffic Fatalities Down in Ohio 206
AMA to Air "Today's Health" Program 210
Book: "Application of the Laser" 212
Obituaries 223
National Rural Health Conference Scheduled ... 242
Chicago Physician to Head OSU OB-Gyn Service 244
Family Practice Director Named at Ohio State .. 288

The Journal's Advertisers

The Journal's Advertisers in This Issue 285
Classified Advertisements 286

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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APR 22 1974

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

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The Ohio State Medical Journal
17 South High Street, Suite 500
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Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

Subscription, $5.00 per year to nonmembers; single copy, 50 cents (outside Continental U.S., $6.50 and 65 cents).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertiser must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

Opinion of Attorney General Regarding DOA Patient

Following is the syllabus of Opinion No. 73-123 by Ohio Attorney General William J. Brown. The opinion was given in response to a question from the prosecuting attorney of a county regarding jurisdiction when a patient is brought to the emergency room of a hospital "dead on arrival."

"1. Under R.C. 313.11 and R.C. 313.12 the coroner does not have jurisdiction over the body of a deceased person unless the death has occurred 'as a result of criminal or other violent means, or by casualty, or by suicide, or suddenly when in apparent health, or in any suspicious or unusual manner.'

"2. When none of the above circumstances are present, the coroner has jurisdiction only if the deceased is unknown, or if those who are entitled to custody of the body do not claim it. R.C. 313.08."

The following excerpt from the detailed opinion would seem of particular interest to hospitals and emergency department personnel.

"*** One of my predecessors has noted the necessity for the presence of trained physicians in the emergency room of a hospital. Opinion No. 3197, Opinions of the Attorney General for 1962, at p. 626. Consequently, if a patient arrives in the emergency room under circumstances which indicate that he is already dead, and if his own physician is unknown or unavailable, R.C. 313.12 requires that he be examined by one of the physicians on duty, and that that physician make the pronouncement of death if the facts so indicate. Only if there are indications of violence, or any other suspicious or unusual circumstances, does R.C. 313.12 direct that the examining physician notify the office of the coroner. ***"

Traffic Fatalities Down in Ohio

Ohio's traffic death rate for 1973 was the lowest in history, while total deaths dropped to 1965 levels, the Ohio Department of Highway Safety announced.

The death rate for the year has been placed at 3.5 deaths per 100 million miles driven, compared with a 3.9 rate in 1972. National average was 4.2, according to the National Safety Council, also down from the 4.5 recorded in 1972.

Preliminary figures show 2,342 traffic deaths occurred in the state in 1973, a 4 percent drop from the 2,451 recorded in 1972. The lowest death toll during the past eight years was 2,333 in 1965 and the highest was 2,778 in 1969.



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What Is SSI (Title XVI) All About?

More Physicians Are Becoming Involved in This SS-Funded Program in Disability Determination

PHYSICIANS will want to know more about the programs for the disabled and blind administered by the Social Security Administration. The Social Security Amendments of 1972 increased substantially the number of people who are being served. As in all federally funded programs, the assistance and cooperation of physicians is critical in assuring prompt, sound decisions on claims for disability benefits filed by patients.

The 1972 amendments provide increased protection for disabled workers and their dependents under the disability insurance program, Title II. This law extends benefits to certain persons disabled before age 22, makes more blind workers eligible, and extends Medicare coverage to persons who have been under Social Security disability roles for at least 24 months.

Also, as a result of these amendments, the existing Federal-State programs of aid to the aged, blind, and permanently and totally disabled have been repealed. In their place a new Supplemental Security Income (SSI) program, Title XVI totally funded by the Federal Government, became effective January 1, 1974. For those who are blind and disabled and in financial need, **the law requires that the SSI disability determinations be made under essentially the same standards as the regular Social Security disability insurance program.** The new program is administered by the Social Security Administration, assisted in Ohio by the Bureau of Disability Determination.

Reporting Medical Evidence

In applying for disability insurance benefits under Title II, a person is required to submit medical evidence to support his claim. This evidence usually consists of data from the records of his treating physician, clinic, or other medical source. Experience with the disability program in Ohio indicates that in about four out of five cases no further medical evidence is needed to make a decision on the claim because the treating source already has enough information on record to provide a good picture of the applicant's condition and how it limits his ability to work.

Under Title XVI, the applicant is not required to submit medical evidence to support his claim. The medical information is requested on the patient's behalf by the Bureau of Disability Determination, Rehabilitation Service Commission through the applicant's own physician or through other medical sources. Like agencies in other states, the Bureau of Disability Determination in Ohio includes both physicians and trained disability examiners on its professional staff. They form a team that can handle everything which bears on the disability decision, from the strictly medical issues to a complete assessment of the vocational factors.

With the assistance of a staff of reviewing physicians, bureau personnel try to make requests for medical information relate as directly as possible to the condition which the claimant states is the cause of his disability. The goal of the individually tailored request is to ease the medical reporting burden of the physician or clinic, without jeopardizing the claimant's right to have his case decided on the basis of all relevant information available.

Importance of the Medical Report

The evaluating physician in the Bureau of Disability Determination never sees the patient. He depends heavily on information supplied by the physician or clinic to assess the severity of the patient's impairment, its expected duration and the extent of his residual functional capacity. The disability decision, therefore, rests largely on the completeness of the medical evidence obtained. A detailed report from the treating source, including objective findings and laboratory procedures, will usually be sufficient for the bureau to evaluate the claims and make a decision.

If a report does not contain all the findings necessary to make a proper decision, one of the reviewing physicians may recontact the medical source. When the medical source does not have the needed objective findings the bureau may purchase an evaluation to obtain the information required. The additional time required may delay the patient's claim, however, and can add up to a significant additional program expense. The physician can help speed the decision on his patient's claim by reporting all relevant data about his medical condition as soon as possible.

Criteria for Evaluating Disability

A person under 65 can receive monthly disability benefits if he has a physical or mental impairment severe enough to prevent him from

The post-T&A patient:
another type for Tylenol
(acetaminophen)



When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.[1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding....Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Reuter, S. H., and Montgomery, W. W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J. B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A. D., and Pearson, H. A.: J. Pediat. *78*:558-560 (March) 1971.

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doing any substantial work for a year or longer. In making disability determinations, the bureau agency uses medical criteria developed by the Social Security Administration. This insures uniform evaluation of all applicants and helps simplify and speed the decision-making process. These criteria were developed with the aid of practicing physicians, major medical organizations and SSA's Medical Advisory Committee.

Further information may be obtained by contacting John E. Hastings, M.D., Chief Medical Consultant, or Richard Leyland, Medical Administrator of the Bureau of Disability Determination, Rehabilitation Services Commission, 4574 Heaton Road, Columbus 43227; or telephone 614/466-3107.

AMA to Air "Today's Health" Programs as Weekly Features

The American Medical Association and Standard Brands, Inc., have jointly announced a new television series titled "Today's Health." Beginning in April, this syndicated weekly half-hour series is designed to explore varied aspects of health and medicine. Material from the AMA *Today's Health,* magazine for lay readers, will be utilized.

The program is being distributed to television stations on a trade basis, and it is hoped that between 60 and 100 TV stations will schedule the weekly feature. It has been estimated that some seven million viewers will see the feature each week.

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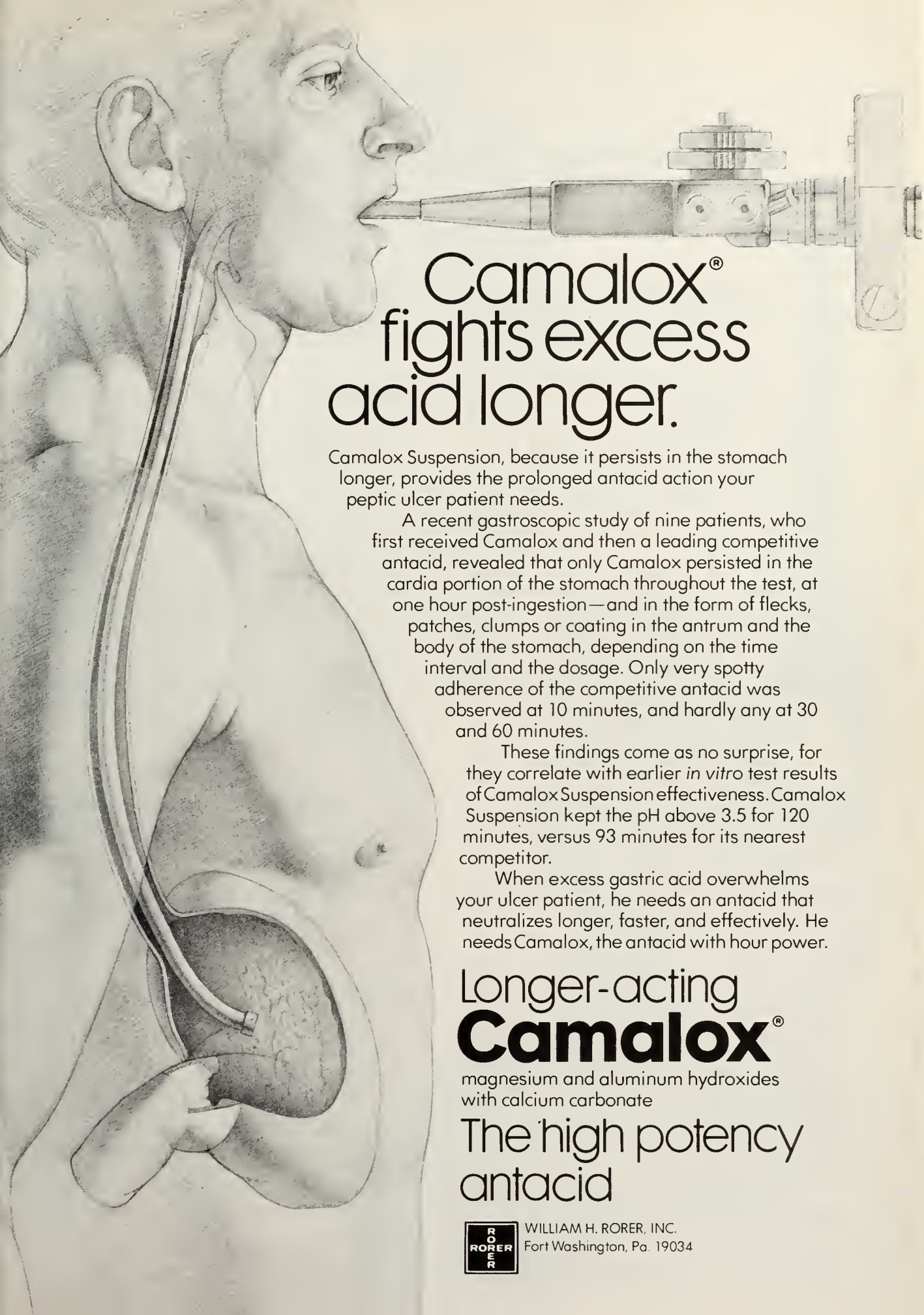
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These findings come as no surprise, for they correlate with earlier *in vitro* test results of Camalox Suspension effectiveness. Camalox Suspension kept the pH above 3.5 for 120 minutes, versus 93 minutes for its nearest competitor.

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Traveling Newborn Workshops Open to Ohio Physicians

OHIO FAMILY PHYSICIANS, pediatricians, and obstetricians are being invited to attend any one of a series of one-day neonatal workshops scheduled for selected community hospitals in 1974, according to an announcement by Dr. Elizabeth R. Aplin, chairman, Ohio Chapter, American Academy of Pediatrics.

The Traveling Newborn Workshops are staffed by members of the Ohio Chapter working under a grant from the Division of Maternal and Child Health (MCH), Ohio Department of Health. The doctor/nurse teams are affiliated with neonatal intensive care centers in Ohio medical centers, Dr. Aplin said.

With a goal of reducing newborn mortality and morbidity, the workshops instruct nurses and physicians on four aspects of newborn care: Resuscitation, oxygen therapy, nutrition, and thermal regulation. In addition, nursery staffs and physicians are told about the evolving regional concept of newborn care and the comparatively new medicopter service available in some areas of Ohio for at-risk newborns and sick children.

The workshop program, begun in April of 1972, has already brought new knowledge to staffs of more than 100 community hospitals, reports Dr. John W. Cashman, State Health Director, who has worked with the Ohio Chapter's Fetus and Newborn Committee. An estimated 1,650 persons have attended the sessions.

"An understanding of how newborns can be entered in a regional or tertiary children's hospital is vital to the family physician," commented Dr. George Shadle, chief of the MCH Division. The tertiary facilities are presently designated as Cincinnati Children's Hospital; Columbus Children's; Babies and Childrens Hospital, in Cleveland; Cleveland Metropolitan General Hospital; and Akron Children's Hospital.

As to the medicopter service, workshop leaders explain what the program consists of, how to recognize the infant that needs to be transported, how to obtain the service, and how to prepare children for air transport. The service is provided by the Ohio National Guard at no cost to the hospital or the patient.

The "flying intensive care units," as they are sometimes called, transport at-risk newborns or sick children to the three children's hospitals bordering the 28 Appalachian counties of Ohio, according to Dr. Shadle, who supervises the medicopter program for the MCH Division.

Medicopters, flown by former Vietnam pilots, are on call seven days a week from Beightler Armory near Columbus and the Canton-Akron Airport in Canton, as well as on weekend call from the National Guard base in Cincinnati.

"The medicopter is not just a fast ambulance to the hospital," explains Dr. Burt Harris, former chief surgical resident at Columbus Children's and a Guard medical unit commander.

"Depending on the location of the patient, helicopter transport might not necessarily save a significant amount of time. The real benefit is that specialists and appropriate equipment can be taken to the patient to deliver needed emergency treatment and stabilize the patient for the trip to the hospital," he said.

All of this and more is explained in the traveling newborn workshops, notes Dr. James Sutherland, chairman of the Ohio Chapter's Fetus and Newborn Committee. He emphasized the workshops are open to family physicians. There is no charge.

Each workshop is scheduled at the convenience of the community hospital requesting the program. Each workshop is publicized in its own community.

Any local hospital wishing to apply for a Traveling Newborn Workshop program should contact Luella Steil, R.N., Newborn Program Coordinator, Division of Maternal and Child Health, Ohio Department of Health, Box 118, Columbus, Ohio 43216.

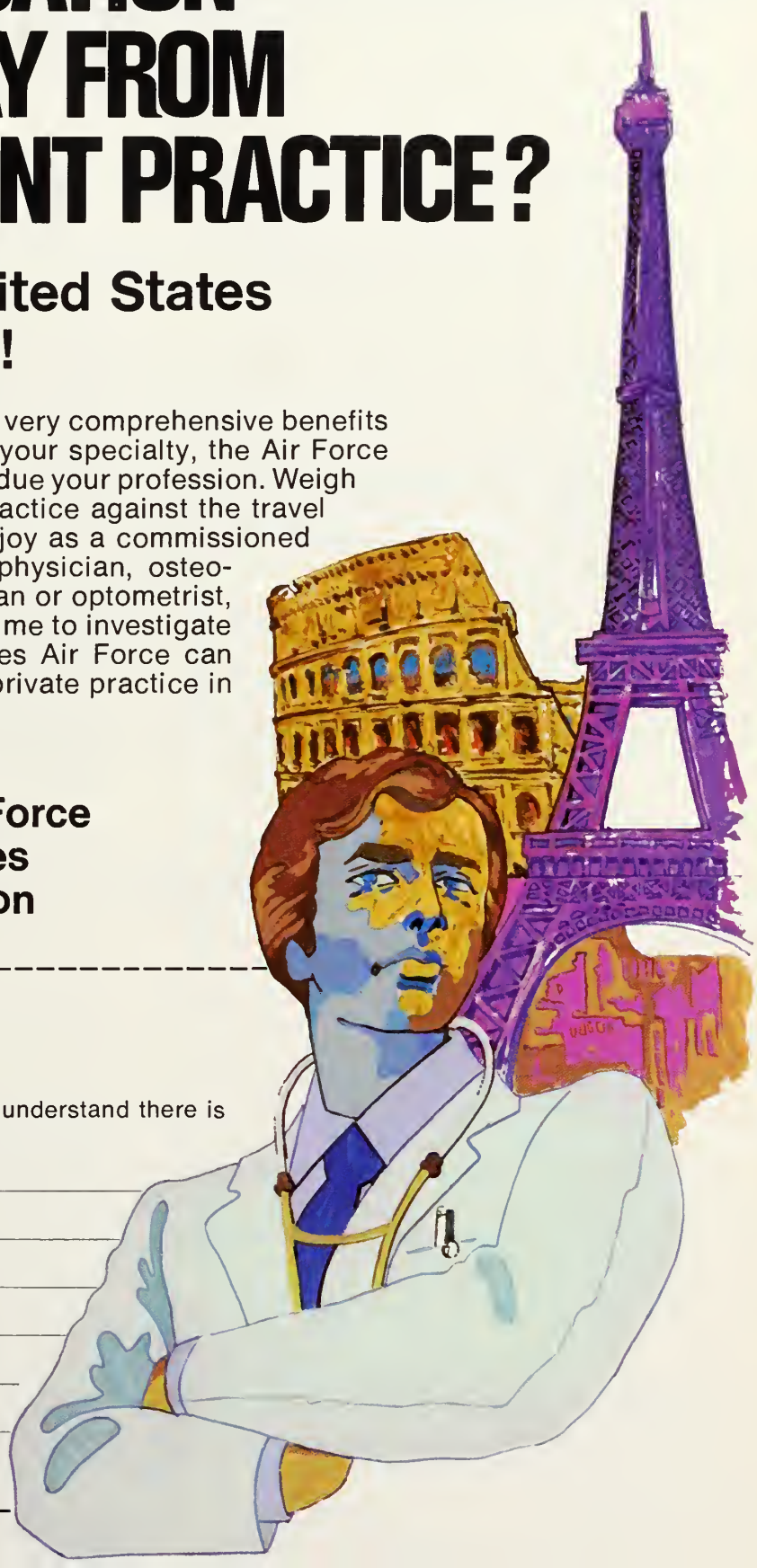
Physician's Bookshelf

Applications of the Laser — The author of this 320-page desk reference is Leon Goldman, M.D., director of the Laser Laboratory, University of Cincinnati Medical Center and professor and chairman of the CU Department of Dermatology. He has spent over 11 years in comprehensive investigation of laser technology. Copies may be ordered from booksellers or from CRC Press, Inc., 18901 Cranwood Parkway, Cleveland 44128. Price, $39.95.

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PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. Patient's name *(First name, middle initial, last name)*	2. Patient's sex ☐ Male ☐ Female	3. Insured's Identifying No. *(Include any letters)*
4. Patient's address *(Street, city, state, ZIP code)*		5. Insured's Group No. *(or Group Name)*
6. If patient has other health insurance, health plan or state assistance, enter its Name, Address and Policy or Medical Assistance Number		
7. Was illness or injury connected with patient's employment? ☐ No ☐ Yes ☐ Unknown		
8. Patient's or authorized person's signature *(Read back before signing)* I authorize the release of any medical information necessary to process this claim. SIGNED	9. Date signed	10. Patient's date of bi
11. Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other		
12. Insured's **name** *(First name, middle initial, last name)* **Address** *(Street, city, state, ZIP code)*	13. I authorize payment of medical benefits to undersigned physician or supplier for service described below. **SIGNED** *(Insured or Authorized Person)*	

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE ILLNESS / INJURY / PREGNANCY — DATE OF FIRST SYMPTOMS / DATE OF ACCIDENT / DATE OF LMP	15 DATE FIRST CONSULTED YOU FOR THIS CONDITION	16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ NO ☐ YES
17 DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK	18 DATES OF PATIENT'S DISABILITY — TOTAL DISABILITY: FROM DATE / THROUGH DATE	PARTIAL DISABILITY: FROM DATE / THROUGH DATE
19 NAME OF REFERRING PHYSICIAN	20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES	DATE ADMITTED / DATE DISCHARGED

21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*

22 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE TO NUMBERS 1, 2, 3, ETC. IN COLUMN D)

1
2
3

23 A — DATE OF EACH SERVICE	B — PLACE OF SERVICE *See codes below	C — DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES) — PROCEDURE CODE	D — DX NO	E — CHARGES *(Explain unusual circumstances in Column C)*	F — LEAVE BLANK

24 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO	25 SOCIAL SECURITY NO.	28 TOTAL CHARGES
	26 EMPLOYER I.D NO	29 AMOUNT PAID
	27. OTHER IDENTIFYING NO	30 BALANCE DUE

31 ACCEPT ASSIGNMENT *(See back)* ☐ YES ☐ NO	32 SIGNATURE OF PHYSICIAN OR SUPPLIER *(Read back before signing)* SIGN HERE	33 DATE SIGNED	34 YOUR PATIENT'S ACCOUNT NO.

*PLACE OF SERVICE CODES

1 – (IH) – INPATIENT HOSPITAL
2 – (OH) – OUTPATIENT HOSPITAL
3 – (O) – DOCTOR'S OFFICE
4 – (H) – PATIENT S HOME
5 – DAY CARE FACILITY (PSY)
6 – NIGHT CARE FACILITY (PSY)
7 – (NH) – NURSING HOME
8 – (SNF) – SKILLED NURSING FACILITY
9 – AMBULANCE
O – (OL) – OTHER LOCATIONS
A – (IL) – INDEPENDENT LABORATORY
B – OTHER MEDICAL/SURGICAL FACIL

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE

Health Insurance Claim Form

Discussion of the Uniform Claim Form for Accident and Health Insurance as Prepared by the American Medical Association

Fulfilling the Need

As a result of the expansion of government programs coupled with the extensive growth of the health insurance industry and the continuous broadening of policy provisions to cover more and more ambulatory services, the physician has found his office saturated with various types of insurance report forms. Many of these report forms are complicated and time consuming to complete.

The American Medical Association's Council on Medical Service and its Committee on Health Care Financing recognized the need to simplify and standardize reporting of physician services for reimbursement under the various types of government programs and third party policies.

To fulfill this need, a Work Group was established to develop a uniform physician reporting form acceptable to the various governmental agencies and health insurance organizations. This Work Group represented an expansion of activities which have been successfully carried on by the AMA and the Health Insurance Council for many years. Specifically, the objectives of the Work Group were to develop a computer adaptable uniform reporting form designed to:

(1) Satisfy the needs of most health insurance organizations and agencies;

(2) Reduce the total costs of claims processing;

(3) Simplify physician reporting and third party processing without impairing system efficiencies and controls; and

(4) Provide a uniform reporting format compatible with PSRO data accumulation requirements.

The Work Group, consisting of members representing the American Medical Association, Bureau of Health Insurance-DHEW, California Medical Association, Health Insurance Council, Medical Group Management Association, Medical Services Administration-DHEW, National Association of Blue Shield Plans, Office of Secretary of Defense, Health, and Environment (CHAMPUS), the Society of Professional Business Consultants, with input from various other professional organizations, has worked diligently to accomplish its stated objectives.

These objectives have been met as evidenced by the development of the Health Insurance Claim Form (shown on facing page). The AMA wishes to express its appreciation for the contributions made by members of the Work Group and for valuable input provided by other organizations. We feel the need has been fulfilled.

Effective Use of the Form

The Work Group members, in designing the Health Insurance Claim Form, recognized the necessity for allowing latitude in how it is to be completed. The form has been designed so that it can be completed on pica and elite typewriters or automatically by computer printers. Also, enough space has been left in the blanks for completion by hand. If the physician stocks these forms, he may order them in single, or multi-part, and if necessary, in continuous form with pin-feed strippings for computer printers.

Governmental agencies and third-party carriers may print this form with certain elements shaded or left blank. In so doing, an area (Element 23, Column F), will be utilized primarily by Blue Shield Plans to accommodate unique requirements on a local basis.

It has become apparent that the amount of office paperwork required of physicians has dramatically increased over the past several years due to third party claims reporting requirements. This added workload has reduced the amount of time available for the physician to render medical care and has increased his practice costs. It is therefore imperative that physicians implement some mechanism to assist them in the collection of data and in the preparation of insurance forms.

One practical solution is the use of charge tickets which are easy for the physician to complete and can supply input for claims reporting and office record keeping. Many variations of charge tickets have been developed, but most are designed for use by individual specialties and contain those procedures which collectively make up approximately 80 percent of the physician's practice. The use of appropriate charge tickets can serve to reduce paperwork, save the physician time, speed the transfer of information, and reduce the total costs of operating a practice.

Since many physicians are presently using a bank or service bureau or in larger group practices have their own computer systems to process their

monthly statements, these same sources can be used to prepare the insurance claim form automatically. Some of the data necessary to process monthly statements is the same type of data as the information contained on the claim form. The charge ticket could be used as a simple keypunch worksheet.

One of the essential elements of a system of this type is that the insurance and patient identifying information would be gathered only once—during the initial encounter. On subsequent encounters, only the patient's account number and data related to the services rendered would be necessary for completion of additional claim forms. More detailed information and samples of charge tickets currently in use can be obtained from the AMA Division of Medical Practice.

Ordering Forms

For the convenience of the physician or supplier, the American Medical Association will stock the standard version of the Health Insurance Claim Form in single, two part (carbonized), and two part continuous form for computer use. Where the physician or supplier wishes to stock this form, he may order it, by completing the enclosed order blanks or by contacting the AMA for additional order blanks.

Conclusion

It is believed by the Council on Medical Service that independent action by state and local medical organizations to develop and promote their own claim form is no longer necessary. The Work Group on Attending Physicians Report Forms is receiving aggressive support of appropriate national organizations and believes that the best interest of all (insured patients, insuring organizations, and physicians) will be best served by having all constructive suggestions for improvements and modifications channeled through the Council on Medical Service and its Committee on Health Care Financing so that they may be considered in conference with the national organizations represented in this effort.

Instructions for Completing the Form

The form has been separated into two major sections—patient information and physician information. The patient and insured (subscriber) section contain eleven data elements and two spaces for signatures. Basically, this section captures Patient Name and Address, Insured's Identifying Number, and Patient's and Insured's Signatures. The physician or supplier information section consists of twenty-one elements. There are, however, few circumstances that would require all of these elements to be completed.

A brief description of each element and its applicability to the requirements of Medicare, Medicaid, and insurance companies is presented below. For more specific information, consult your local intermediary or third party carrier. (For all Blue Shield and CHAMPUS claims, refer to local instructions provided by these organizations.)

It should be noted that "insured" is the same as the policyholder or subscriber. The employee is the insured under group policies. "Dependents" refers to those persons eligible for coverage under the insured's policy. The term "patient" may refer to either the insured or a dependent.

Order Blank
Health Insurance Claim Form

Return Order Blank To:
American Medical Association
535 North Dearborn
Chicago, Illinois 60610
(312) 751-6000

Type of form		Quantity – in orders of:		Price Including Handling and Postage
☐ Single Form (One page pads of a hundred)	OP-407	1,000	☐	$ 18.50
		5,000	☐	78.00
		10,000	☐	138.00
☐ Two Forms (Original and one carbon)	OP-408	1,000	☐	28.00
		5,000	☐	112.00
		10,000	☐	210.00
☐ Continuous Form (Original and one carbon) (For Computer Printers)	OP-409	1,000	☐	28.00
		5,000	☐	112.00
		10,000	☐	210.00

TOTAL _____

CHECK ☐ Enclosed MONEY ORDER ☐ Enclosed

Type or Print

Name_____

Street Address_____

City_____ State_____ Zip_____

Check or money order must accompany this order and be made payable to the American Medical Association.

NOTE: Larger quantities available at special rates. Call or write the American Medical Association.

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or



Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema nasal congestion and excessive upper respiratory secretions thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children particularly antihistamines in overdosage may produce convulsions and death
PRECAUTIONS. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery etc Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol hypnotics, sedatives tranquilizers, etc.
ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash urticaria, leukopenia agranulocytosis, and thrombocytopenia; drowsiness lassitude, giddiness dryness of the mucous membranes tightness of the chest, thickening of bronchial secretions urinary frequency and dysuria palpitation, hypotension/hypertension, headache, faintness dizziness tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation and epigastric distress.
HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23220

when pain goes on... and on... and on–



For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming)

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. A·H·ROBINS

Community Health News

Ohio Department of Health

JOHN H. ACKERMAN, M.D., Deputy Director

1. Influenza and Reye's Syndrome

Ohio is currently experiencing a wide spread outbreak of Type B influenza. Recent studies have shown an increase in the incidence of Reye's Syndrome associated with outbreaks of Type B influenza.

The Department is anxious to collect as much information as possible on Reye's Syndrome. We would ask your cooperation in reporting confirmed or suspected cases of Reye's Syndrome to the Communicable Disease Division.

2. Hemophilia

A hemophilia program was authorized for the Department in the last session of the General Assembly. Although funds are limited, we are currently developing programs to assist victims of this disease.

We are developing a directory of individuals with hemophilia. Physicians will soon be contacted for information on patients whom they are treating for this disorder. We will appreciate your cooperation in providing the information, which, of course, will be held in confidence within the Department.

we can provide some form of health insurance to . . .

99%

of OSMA members—regardless of health history

Complete protection is available for you and your family with the OSMA sponsored Extra Cash Hospital Plan and comprehensive Major Medical Insurance. Also available to Ohio physicians are Disability Income Protection, Practice Overhead Expense Protection and Accidental Death, Dismemberment and Disability Insurance. Choose the plans that fill your insurance needs and send the coupon today for complete details. Or better yet, for immediate information, call us collect!

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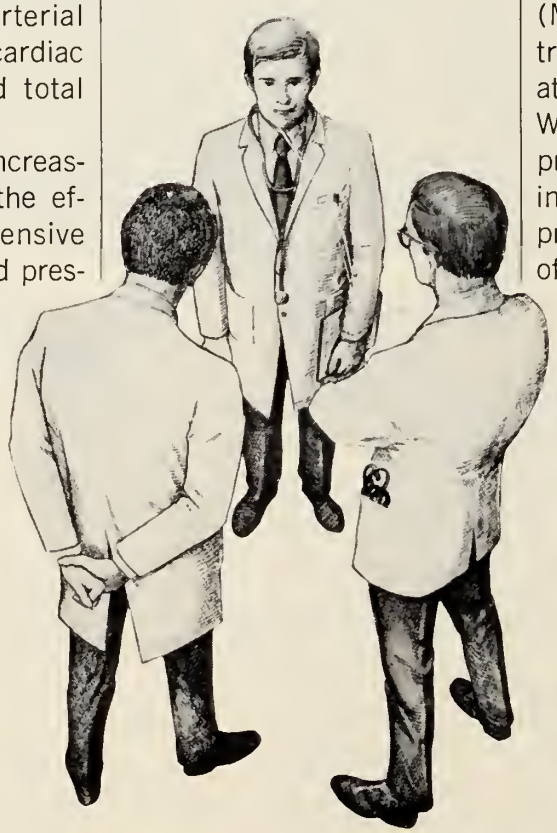
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☐ PRACTICE OVERHEAD EXPENSE PROTECTION
☐ ACCIDENTAL DEATH, DISMEMBERMENT and DISABILITY INSURANCE
☐ LIFE INSURANCE

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City_____
State_____ Zip_____

The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

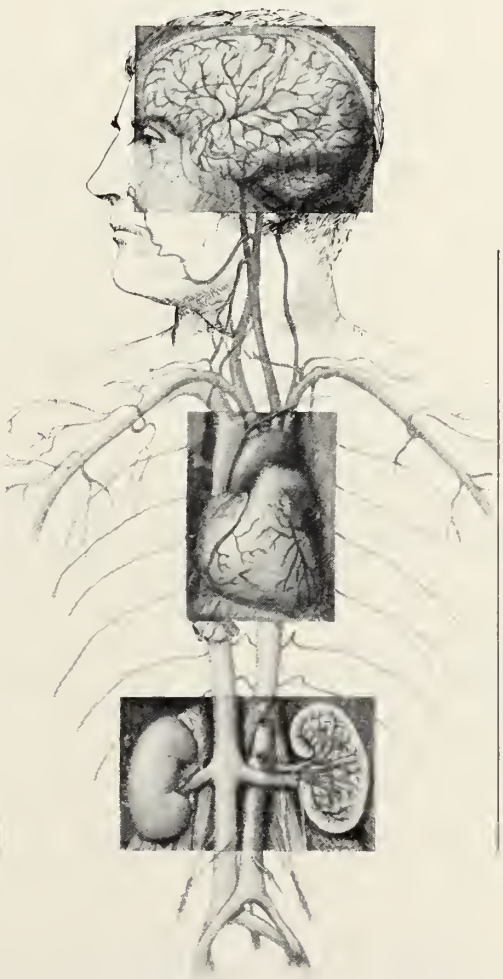
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?



With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in

the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Some patients on continuous methyldopa therapy may develop a positive direct Coombs test. For more details, see the brief summary of prescribing information.

Contraindicated in active hepatic disease and known sensitivity to the drug. Not recommended in pheochromocytoma or pregnancy. It should be used with caution in patients with a history of liver disease or dysfunction. Discontinue the drug if fever, abnormal liver function, jaundice, or acquired hemolytic anemia occurs.

In most cases of sustained moderate hypertension

TABLETS, 250 mg

ALDOMET®
(METHYLDOPA | MSD)

smoothly lowers blood pressure

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

TABLETS, 250 mg

ALDOMET® (METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: Acquired hemolytic anemia has occurred rarely in association with therapy with methyldopa. Should clinical symptoms indicate the possibility of anemia, hemoglobin and/or hematocrit determinations should be performed. If anemia is present, appropriate laboratory studies should be done to determine if hemolysis is present. Evidence of hemolytic anemia is an indication for discontinuation of the drug. Discontinuation of methyldopa alone or the initiation of adrenocortical steroids usually results in a prompt remission of the anemia. Rarely, however, fatalities have occurred.

Some patients on continued therapy with methyldopa develop a positive direct Coombs test; incidence reported has averaged between 10% and 20%. It rarely occurs in first six months of therapy, and if not seen within twelve months, is unlikely to develop with continued administration. Positive Coombs test is dose-related; lowest incidence occurs in patients on 1 g methyldopa or less per day. Reversal of the positive Coombs test occurs within weeks to months after discontinuation of methyldopa. Prior knowledge of a positive Coombs reaction aids in evaluation of cross match for transfusions. Patients with positive Coombs tests at time of cross match may exhibit incompatible minor cross match. When this occurs, an indirect Coombs test should be performed. If negative, transfusion with blood otherwise compatible in the major cross match may be carried out. If positive, advisability of transfusion with blood compatible in major cross match should be determined by hematologist or expert in transfusion problems.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rare cases of fatal hepatic necrosis have been reported. Liver biopsy in several patients with liver dysfunction has shown microscopic focal necrosis compatible with drug hypersensitivity. Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen; reversible agranulocytosis has been reported. Methyldopa may interfere with measurement of creatinine by alkaline picrate method and of uric acid by phosphotungstate method. When used with other antihypertensive drugs, potentiation of antihypertensive action may occur.

Usage in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Perform periodic hepatic function tests and white cell and differential blood counts during first six to twelve weeks of therapy or in unexplained fever. Discontinue if fever, abnormalities in liver function tests, or jaundice appears. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Discontinue drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Anesthetics requirements may be reduced; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension may occur after dialysis because methyldopa is removed by this procedure.

Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Do not exceed recommended daily dose of 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure, including dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency, are seen occasionally. Angina pectoris may be aggravated. Symptoms of orthostatic and exercise hypotension may occur; if symptoms occur, reduce dosage. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distension, constipation, flatus, and diarrhea occur occasionally; these can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently; if edema progresses or signs of pulmonary congestion appear, discontinue drug. Rarely, urine exposed to air may darken due to breakdown of methyldopa or its metabolites. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression, reversible thrombocytopenia, drug-related fever and abnormal liver function studies with jaundice and hepatocellular damage (see **Warnings** and **Precautions**), rise in BUN, and a single case of bilateral Bell's palsy.

Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD
MERCK SHARP & DOHME

ADDENDUM

Let's make blood pressure "required reading" for all physicians.

With recent estimates that about 23 million Americans have high blood pressure—and that half of them are not even aware of it—detection of the problem in asymptomatic persons has become an issue of national importance.

Family physicians are being urged to take blood pressure readings as a matter of office routine, regardless of the presenting complaint or the reason for the visit. And because many people do not see a family physician for relatively long periods of time, some experts are suggesting that ophthalmologists, gynecologists, dermatologists, orthopedists, psychiatrists, dentists, school nurses, family planning counselors, and other health-care personnel make blood pressure reading a routine part of every examination or consultation.

Of course, a diagnosis of hypertension cannot be made on the basis of a single reading, but routine blood pressure readings can uncover potential trouble in a certain proportion of patients. And when trouble is suggested, further evaluation can be pursued more effectively.



Blood pressure—"required reading" for all physicians.

Obituaries

Daniel George Arnold, M.D., Bucyrus; University of Michigan Medical School, 1925; aged 72; died February 22; member of OSMA and AMA.

Elizabeth Clark Brewster, M.D., Cincinnati; University of Cincinnati College of Medicine, 1925; aged 87; died January 31; member of OSMA and AMA.

David Brown, M.D., Bellaire; Ohio State University College of Medicine, 1935; aged 66; died January 27; member of OSMA and former member of AMA.

Isadore R. Cohn, M.D., Toledo; State University of New York Upstate Medical Center, Syracuse, 1922; aged 76; died February 7; member of OSMA and AMA.

Edwin Charles Faessler, M.D., Cincinnati; University of Cincinnati College of Medicine, 1941; aged 58; died February 3; member of OSMA and AMA.

Anna J. Waite Gillam, M.D., Wooster; Woman's Medical College of Pennsylvania, 1910; aged 93; died recently; member of OSMA and AMA.

Ernest Gottschalk, M.D., Toledo; University of Giessen, Germany, 1919; aged 82; died February 14; member of OSMA and AMA.

Charles Llewellyn Hannum, M.D., Strongsville; Western Reserve University School of Medicine, 1930; aged 69; died February 24; member of OSMA and AMA.

Kazimir Janecki, M.D., Belpre; medical degree from the University of Jana Kazimierza, Lwow (Poland), 1928; aged 73; died recently; former member of OSMA and AMA.

Harry Oscar Lepsky, M.D., Cincinnati; University of Cincinnati College of Medicine, 1932; aged 64; died November 28; member of OSMA and AMA.

Charles Burton Lewis, M.D., North Olmsted; Western Reserve University School of Medicine, 1928; aged 75; died January 31; member of OSMA and AMA.

Eugene H. Merrell, M.D., Geneva; Ohio State University College of Medicine, 1926; aged 70; died January 28; member of OSMA and AMA.

Jacob Wise Old, Jr., M.D., Columbus; Washington University School of Medicine, 1946; aged 52; died December 30; former member of OSMA and AMA.

Lester Seligson, M.D., Columbus; Ohio State University College of Medicine, 1927; aged 76; died January 30; member of OSMA and AMA.

Russell F. Wiggers, M.D., Cincinnati; University of Cincinnati College of Medicine, 1941; aged 60; died January 29; member of OSMA and AMA.



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Android®-25 Tablets

Android-10 Tablets **Android-5** Buccal

Methyltestosterone N.F. —25, 10, 5 mg.

For the treatment of impotence due to androgenic deficiency in the male.

DESCRIPTION: Methyltestostarone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Malhyltestosterone is en oil soluble androgenic hormone. **INDICATIONS:** In tha mala: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms whan thasa ara secondery to androgen deficiency. 3. Impotance dua to androganic deficiancy. 4. Postpuberal cryptorchidism with avidenca of hypogonadism. Choleetatic hepatitis with jeundica and altered liver function tests, auch as incraasad BSP ratention and risas in SGOT lavels, have been raportad aftar Methyltestostarona. These changes appear to ba relatad to dosaga of tha drug. Therefore, in tha presence of any changes in liver function leste, drug should ba discontinuad. **PRECAUTIONS:** Prolonged dosage of androgen may rasult in sodium and fluid ratention. This may prasant a problem, especially in patianta with compromised cardiac raaarve or ranal disease. In treating malas for symptoms of climacteric, avoid stimulation to tha point of increasing the narvous, mental, and physical activities bayond tha patient's cardiovaacular capacity. **CONTRAINDICATIONS:** Contraindicated in parsons with known or euepacted carcinoma of the prostele and in carcinoma of tha male breast. Contraindicatad in tha presenca of severe liver damage. **WARNINGS:** If priapism or other aigns of excassiva saxual stimulation devalop, discontinue tharapy. In tha mala, prolongad adminietration or excessive doaage may causa inhibition of testicular function, with rasultant oligospermia end decrease in ejaculatory voluma. Usa cautiously in young boya to avoid pramatura apiphyseal closura or precocious saxual davalopment. Hyparsaneitivity and gynecomastia may occur raraly. PBI mey be decreased in patiants taking androgans. Hypercalcemia may occur, particularly during tharapy for malastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundica • Oligospermia and dacraaaad ejaculatory volume • Hypercalcemia particularly in patients with metastatic braast carcinoma. This usually indicates progression of bona metastasas • Sodium and water refention • Priapism • Virilization in famale patients • Hypersensitivity and gynacomastia. **DOSAGE AND ADMINISTRATION:** Dosaga must be strictly individualizad, as patients vary widely in raquirements. Daily requirements ara bast administarad in dividad doses. Tha following is suggestad aa an averaga daily dosaga guida. **In the male:** Eunuchoidism and aunuchism, 10 to 40 mg.; Mala climacteric symptoms and impotance due to androgen deficiancy, 10 to 40 mg.; Postpubaral cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th St., Los Angeles, CA 90057

REFER TO PDR

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Mead Johnson LABORATORIES

Continuing Education Opportunities for Physicians in Ohio

April

Family Relations Work — Sponsored by the Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; place of meeting, Sawmill Creek Lodge, Huron; April 19-21.

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106:

Infection Control, April 17-18.

Ohio State University College of Medicine, Continuing Medical Educational Conferences; for details, contact OSU Center for Continuing Medical Education, 410 W. Tenth Ave., Columbus 43210:

Spinal Cord Injuries, April 18-19.

Care of the Burned Patient, April 24.

University of Cincinnati College of Medicine, Office of CONMED, 114 Medical College Bldg., Cincinnati 45219:

Ophthalmology — Cosponsored by the Ohio Society for the Prevention of Blindness, April 19.

Seminars on Fundamentals of Surgery — Sponsored by the Medical College of Ohio at Toledo, Saturdays, 10:00 a.m. to noon; Room G-1, MCO; **Gastrointestinal System,** April 6, 20, 27.

Clinical Seminars on Emergency Medicine — Sponsored by the Medical College of Ohio: April 16 — at Good Samaritan Hospital, Sandusky, 4:00-9:00 p.m., **Pancreatitis.**

May

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106:

Symposium on Hydrocephalus Pathogenesis Diagnosis and Treatment — May 1-2.

Plastic Surgery for the General Surgeon — May 8-9.

Advances in Antibiotics and Infectious Diseases — May 22-23.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Ohio State University College of Medicine, Continuing Medical Education Conferences; for details contact OSU Center for Continuing Medical Education, 410 W. Tenth St., Columbus 43210:

Newborn Conference — May 1-2.

Blood Therapy — May 8.

Gynecologic Endoscopy—St. Luke's Hospital, Cleveland; May 8-9; fee $150; contact Amir H. Ansari, M.D., Div. of Reproductive Physiology. Dept. of Obstetrics and Gynecology, 11311 Shaker Blvd., Cleveland 44104; phone 216/791-1000, Ext. 360.

University of Cincinnati College of Medicine, Office of CONMED, 114 Medical College Bldg., Cincinnati 45219:

Life-Saving Measures for the Critically Injured — Sponsored by *American College of Surgeons Committee on Trauma* in cooperation with UC, at the Shriner's Burns Institute, 202 Goodman St., May 8-10.

Speech Pathology — At the Shrine Burns Institute, May 10.

Abdominal Surgery — At Shrine Burns Institute, May 15-16.

Midwest Ophthalmology Symposium — At Shrine Burns Institute, May 17-18.

Recent Advances in Reproductive Physiology —St. Luke's Hospital, Cleveland; May 10; fee, $75; residents, $35; contact Amir H. Ansari, M.D., Div. of Reproductive Physiology, Dept. of Obstetrics and Gynecology, 11311 Shaker Blvd., Cleveland 44104; phone 216/791-1000, Ext. 360.

Educational Opportunities in Ohio — *Continued*

May (Continued)

Seminars on Fundamentals of Surgery — Sponsored by the Medical College of Ohio at Toledo, Saturdays, 10:00 a.m. to noon; Room G-1, MCO; **Gastrointestinal System,** May 4; **Trauma,** May 11, 18.

Symposium on Pediatric Trauma — at the Medical College of Ohio at Toledo (West Campus), May 17-18; cosponsored by Ohio Committee on Trauma, American College of Surgeons; American Trauma Society, Ohio Chapter; Toledo Pediatric Society and Toledo Surgical Society.

Clinical Seminars on Emergency Medicine — Sponsored by the Medical College of Ohio:
May 1 — at Holiday Inn, Napoleon, 4:00-9:00 p.m., **Regional Enteritis/Ulcerative Colitis.**
May 9 — at Blanchard Valley Hospital, Findlay, 1:00-5:00 p.m., **Poisonings.**
May 29 — at Flower Hospital, Toledo; 4:00-9:00 p.m., **Acute Postoperative Surgical Emergency.**

Fourth Annual Radiological Seminar — Veterans Administration Center, 4100 W. Third St., Dayton; May 29, from 8:30 a.m. to 4:15 p.m.; contact: Emil Gutman, M.D., Chief, Radiology Service, Veterans Administration Center, Dayton 45428.

June

University of Cincinnati College of Medicine (CONMED); Contact CONMED, 114 Medical College Bldg., Eden and Bethesda Aves., Cincinnati 45219:

Renal Disease Symposium — At Shrine Burns Institute, June 6.

Diagnostic Roentgenology — 16th Annual Refresher Course sponsored by the Radiology Department under direction of Dr. Benjamin Felson, June 10-14.

Medical Economics Seminar Combined with a Rhine River Cruise — Sponsored by the Medi-Club of the Academy of Medicine of Cincinnati, June 4-12.

Clinical Seminars on Emergency Medicine — Sponsored by the Medical College of Ohio:
June 5 — at Hardin Memorial Hospital, Kenton; 4:00-9:00 p.m.; tentative topic, **Surgical Emergency.**
June 11 — at Fisher-Titus Hospital, Norwalk; 4:00-9:00 p.m., **Burns.**

Seminars on Fundamentals of Surgery — Sponsored by the Medical College of Ohio at Toledo; Saturdays, 10:00 a.m. to noon; Room G-1, MCO. **Trauma,** June 1, 8, 15. For the June 8 seminar, visiting professor will be LaSalle D. Leffall, M.D., Howard University, whose topic will be **Abdominal Trauma.**

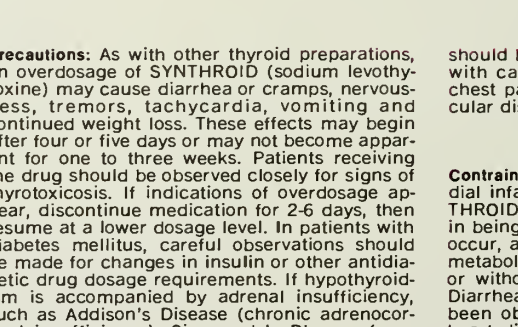
September

Pediatrics and the Practicing Physician — Symposium sponsored by the Medical College of Ohio at Toledo and the Toledo Pediatric Society, Sept. 20-22, at Sheraton Westgate, Toledo. For additional information, write: Howard S. Madigan, M.D., MCO, P. O. Box 6190, Toledo 43614.

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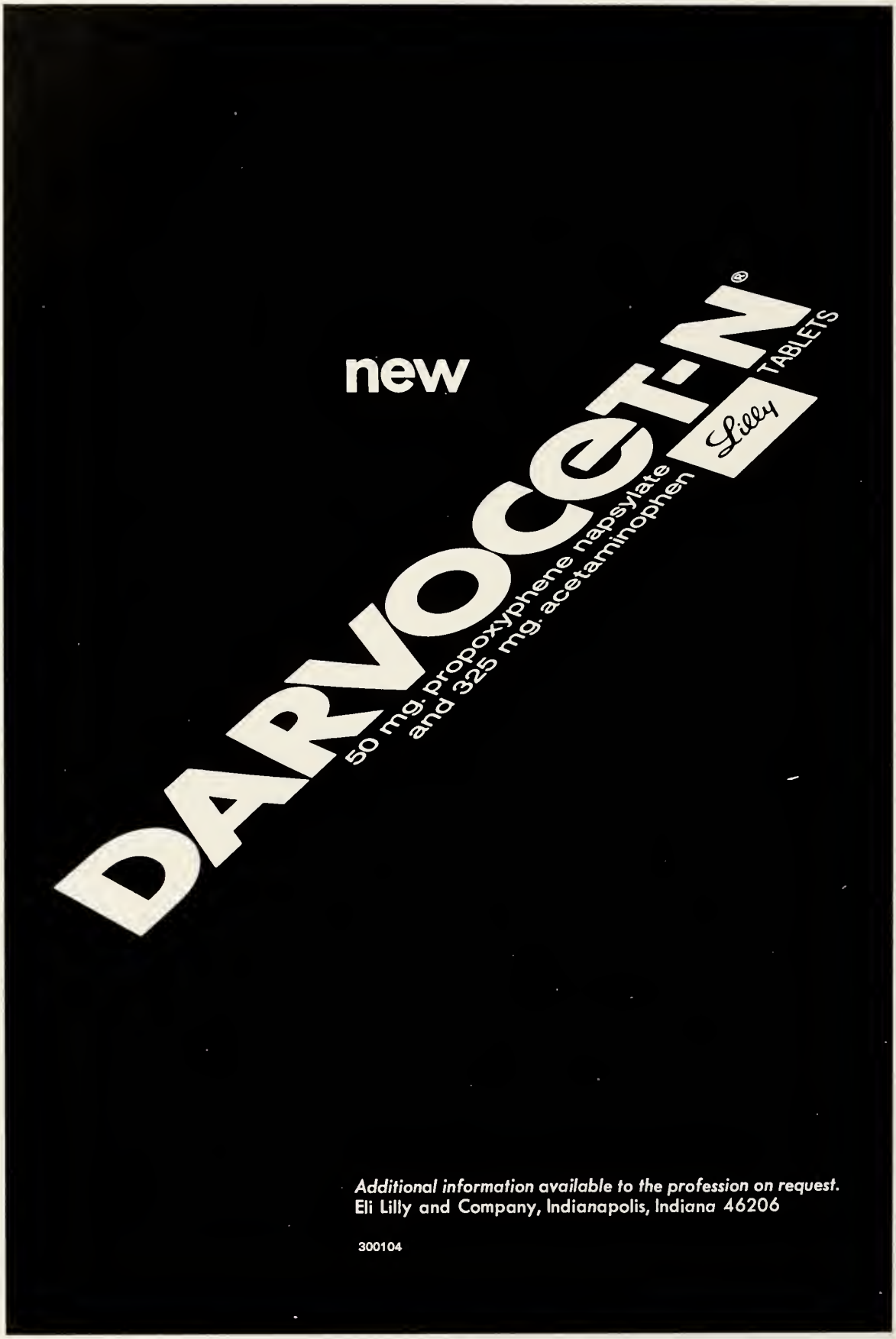
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VOLUME 70 APRIL 1974 NUMBER 4

Intestinal Cancer in the Peutz-Jeghers Syndrome

A Re-evaluation

JOHN D. REID, M.D., AND MARY PETRELLI, M.B.

THE PEUTZ-JEGHERS SYNDROME is characterized by pigmented spots on the lips, buccal mucosa, face, and hands, with, as its second major feature, polyps throughout the gastrointestinal tract. The syndrome is believed to be transmitted in autosomal dominant fashion, with variable penetrance. Sporadic cases are not uncommon, possibly due to genetic mutation. Ever since the syndrome was first delineated in 1949, there has been debate on the possibility that carcinoma might develop by malignant change in the intestinal polyps. Jeghers, et al[1] concluded that "the well known tendency for multiple polyposis of the colon to develop malignancy apparently holds to some degree for the small bowel polyps in cases of this sydrome." This was supported by early reviews in which cancer was found to be present in 20 percent[2] to 24 percent[3] of cases; as late as 1972, a figure of 24.6 percent was given by Ito, et al.[4] Others, beginning with Bartholomew, et al[5,6] and Dormandy,[7] discounted the risk of malignancy as negligible, attributing diagnoses of carcinoma to histologic misinterpretations. Apparent muscular invasion was ascribed to an admixture of acini and muscle in a hamartomatous (myoglandular) polyp;[5,6] and serosal involvement was explained as a growth anomaly[7] comparable to that seen in colitis cystica profunda.[8] Cases of metastasizing carcinoma were reported from 1955,[9] but whether or not these had arisen in polyps of the Peutz-Jeghers type was again disputed,[10,11] partly because

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Submitted September 20, 1973.

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of the claim that the polyps were hamartomas and, as such, believed to be without added risk of malignancy.

This paper is a re-evaluation, on evidence available through the end of 1972, of four questions: (1) whether there is an increased frequency of intestinal cancer in patients with the Peutz-Jeghers syndrome; (2) whether the intestinal polyps are all hamartomas and uniformly normal in structure; (3) whether any carcinomas have been proven to have developed in hamartomatous polyps; and (4) whether any particular segment of the intestine is more at risk than another.

1. *Is there an increased frequency of intestinal cancer in the Peutz-Jeghers syndrome?*

The literature contains 27 cases,[1,2,7,12-30] which have been reported as adenocarcinoma, but which lack any description of mural invasion or metastases (Table 1.) Some were diagnosed as carcinoma in situ or were described with invasion of the stalk only. In the original case reported by Peutz in 1921, the pathologist (Landsteiner) gave a good description of jejunal polyps with at least in situ carcinoma.[12] "In certain places there is a remarkable microscopic change in glands. The cells are no longer in parallel arrangement; the nuclei are elongated in shape and more irregular. Here and there some are even four times larger than normal and are densely staining. These are so arranged that they occupy almost the entire epithelial layer, leaving only a small amount of cytoplasm. In addition, the epithelium is considerably thickened. In these areas goblet cells are absent. In several areas, there is papillary formation. The two kinds of epithelium are clearly distinguished by their appearance. Conclusion: Glandular polyps with malignant degeneration, i.e. early development of adenocarcinoma." (Translation by Dr. H. B. Oey.) Other cases lack adequate description. In the third case published by Jeghers, et al,[1] the diagnosis of adenocarcinoma of the ileum was ac-

Table 1. Cases Stated to Be Adenocarcinoma; Without Further Description; or Without Evidence for Mural Invasion or Metastases

	Author	Sex	Age	Location and Pathologic Description
1.	Peutz 1921[12]	M	15	Jejunum: adenocarcinoma in polyp
2.	Foster 1944,[13] case 1	M	43	Jejunum: adenomatous polyp with anaplasia and adenocarcinomatous transformation
3.	case 2	F	16	Ileum: polyp with anaplasia and invasion of pedicle; adenocarcinoma
4.	Jeghers 1949[1] case 3	F	22	Ileum: adenocarcinoma
5.	Fisher 1951[14]	M	7	Jejunum: adenocarcinoma extending through muscularis
6.	Brayton and Norris 1954[15] case 2	F	15	Jejunum: polypoid adenocarcinoma
7.	Smith 1954[16]	F	29	Ileum: adenocarcinoma with invasion of stroma
8.	Troxell 1954[17]	M	77	Rectum: malignant polyp
9.	Weber 1954[18]	F	15	Jejunum: adenocarcinoma
10.	Berkowitz 1955[2] case 1	F	34	Ileum: carcinoma in situ
11.	Kleitsch, et al, 1955[19]	M	23	Jejunum: adenocarcinoma with invasion of stalk
12.	Sohmer, and Cayer 1955[20]	M	37	Left colon and cecum: adenocarcinoma in polyps
13.	Dormandy 1957[7] case 4	M	67	Rectum
14.	case 7	M	68	Rectum
15.	case 14	M	51	Rectum
16.	case 15	F	60	Stomach and rectum: malignant change (autopsy)
17.	Fung 1957[21]	M	15	Jejunum: adenomatous tissue in pedicle
18.	Rohrs 1957[22]	M	22	Jejunum: two polyps with frank malignant degeneration at periphery
19.	Yoshida, et al 1964[23]	F	71	Gastric polyp: carcinoma in mucosa; undifferentiated
20.	Schlosser, et al 1968[24]	M	38	Small intestine: inoperable carcinoma
21.	Vankatesan 1969[25]	M	13	Stomach: polyp with tendency toward malignancy
22.	Guillard, et al 1970[26]	M	49	Colonic polyps, two with development of glandular epithelioma but not invasive
23.	Simonyi, et al 1970[27]	M	25	Cecum: inoperable cancer
24.	Kimura, et al 1971[28]	M	49	Colonic polyps: focal malignant changes in two
25.	Dodds, et al 1972[29] case 1	M	26	Transverse colon: adenocarcinoma extending into submucosa
26.	case 2	M	52	Splenic flexure: adenocarcinoma
27.	Prathnadi and Rerkasem 1972[30]	M	38	Carcinoma rectosigmoid

cepted on later review by a second pathologist.[31] However, since the patient was only 22 years of age and since the hamartomatous nature of these polyps was not appreciated at this time, this interpretation may legitimately be questioned. Some tumors[23,26,28,29] have been specified as in situ or superficial carcinoma since 1957 when the possibility of hamartoma was probably known and considered by the reporting pathologist. Other cases have been clinically inoperable.[24,27]

Since histologic material cannot be reviewed, it is necessary to rely on the descriptions given and we have accepted those diagnoses of carcinoma in which the authors were apparently aware of the possibility of a hamartoma; cases which were inoperable; or in which there was specific mention of irregular, enlarged and hyperchromatic nuclei and mitotic figures; particularly if the epithelium was also described as multilayered and glands as irregular. By these criteria, 12 of this group of 27 were in situ or invasive cancer (Table 1; Nos. 1, 13-16, 19, 20, 23-27).

The literature includes a further 16 cases in which mural invasion is described with glands extending into the muscularis propria, the subserosa, the serosa or adjacent tissues.[3,7,10,14, 32-37] Not all were reported as carcinoma, but we have reviewed them because of the description of invasion. The problem here is to distinguish between malignant and benign ectopia, the latter being comparable to the Rokitansky-Aschoff sinuses of the gallbladder or to colitis cystica profunda. Correct interpretation is admittedly difficult as evidenced from reported cases. One patient diagnosed in 1958 as a case of carcinoma because of serosal invasion[34] underwent laparotomy in 1971 and was carefully examined without finding any evidence of tumor, as reported in 1972 in a personal communication from M. S. Beinfield, M.D. On the other hand, in the case reported by Freeman and Ravdin[9] where carcinoma was similarly diagnosed by the same criteria, death occurred two years later with metastases.[31] We have accepted five cases as carcinoma because of reported invasion of the peripheral nerves or lymphatics; or because of clear histologic descriptions of malignancy as opposed to ectopic normal glandular tissue (Table 2, Nos. 4, 11, 13, 15, 16).

Fifteen cases of metastatic cancer have now been published (Table 3), and a further instance has been documented to us in detail in a personal communication from Dr. G. Strauch in 1972. This has special interest since the patient was the mother of case 3 in the original paper by Jeghers, et al.[1]

To decide if the 33 cases accepted as cancer indicate an increased frequency of malignancy, it is first necessary to relate them to the total number

Table 2. Cases with Description of Mural, Serosal, Mesenteric, or Peripheral Invasion, Whether or Not Reported as Carcinoma

Author	Sex	Age	Location and Pathologic Description
1. Fisher 1951[14]	M	7	Jejunum: Adenocarcinoma with solid colloid change, direct extension through muscularis of wall
2. Basu 1952[32]	F	25	Ileum and jejunum: Hyperchromatic cells, muscular and subserosal invasion
3. Brockhaus and Jochmus 1956[33]	F	12	Jejunum: Pleomorphic nuclei, mucus secreting adenocarcinoma
4. Bailey 1957[3] case 2	M	66	Rectum: Carcinoma confirmed by biopsy; invasion of sacrum
5. Dormandy 1957[7] case 1	M	22	Small intestine: (1) Adenomas infiltrating muscle layer and submucosa (2) Microadenomas with irregular hyperchromatic cells
6. case 2	M	65	Jejunum: Invasion of wall
7. case 3	M	17	Ileum: Adenomatous "diverticulum" and micropolyposis
8. case 15	F	60	Jejuno-Ileum: Micropolyposis with invasion
9. Beinfield and Changus 1958[34]	M	39	Ileum: Adenocarcinoma; serosal involvement; no evidence of recurrence at laparotomy 1971
10. de la Pava, et al 1962[35]	F	11	Jejunum: Serosal and peritoneal involvement with uniform cells; pattern interpreted as carcinoma
11. Humphries, et al 1966[36]	F	41	Colon: Polyp with invasion of stalk, "wall" and lymphatics
12. Beck and Jewett 1967[10]	F	9½	Ileum: Penetration to subserosa; no pleomorphism or mitoses
13. Bernell 1968[8]	F	30	Stomach: Well differentiated adenocarcinoma with extension to subserosa
14. Shibata and Phillips 1970[37]	M	72	Colon: Infiltration of pericolic fat; invasion of lymphatics and blood vessels
15. Ito, et al 1972[4]	M	65	Colon: Submucosal and muscle involvement; partly medullary pattern

of cases of the syndrome, and then to compare these figures with those relating to gastrointestinal cancer in the general population. To update the review of 366 cases provided by Dozois, et al,[11] we have searched subsequent titles in the Cumulated Index Medicus through December 1972. We have considered, and where necessary, translated each report; and have accepted a further 166 cases, therefore, the total is 492. This gives a figure of 3.2 percent for indisputable cases of metastatic cancer (16 cases) and a further 3.4 percent for nonmetastatic neoplasia (17 cases).

Because of the world-wide origin of reports on the Peutz-Jeghers syndrome, ordinary cancer must be compared in an equally broad geographical setting. However gastrointestinal cancer shows very wide variations in frequency in different countries,[52] and we have been unable to derive a general overall rate. We, therefore, have found it impossible to establish on a statistical basis that there is any increased risk of intestinal cancer in the Peutz-Jeghers syndrome.

As shown later, an unusually high proportion of these cancers occur in segments of the intestine which ordinarily are least affected. Further, the mean age at diagnosis is approximately 35 years which is significantly lower than the 55-to-74 year bracket which covers gastrointestinal malignancy in general. There is thus a strong inference that there is a small added risk of intestinal carcinoma in the Peutz-Jeghers syndrome.

2. *Are all the polyps in the Peutz-Jeghers syndrome hamartomas; and do all the hamartomatous polyps have an entirely normal mucosa?*

In patients with the Peutz-Jeghers syndrome, many polyps have been described as adenomas without further qualification. However, it is difficult to be certain that pathologists have always distinguished between different histologic types, at least before 1957 when the hamartomatous variety was defined.[5,6] It has been specifically stated[41] that polyps of the stomach and rectum may be indistinguishable from the ordinary adenomatous polyp. In the colon, both the myoglandular and the adenomatous polyp may coexist, and carcinoma has been reported developing in the latter.[49] In the small intestine, we have not found any clear report of a polyp which was not myoglandular in structure.

Most recent authors[8,53-55] have agreed that the Peutz-Jeghers polyps are hamartomas, because of the arborizing muscular stroma clothed with an epithelium which is appropriate and normal for the particular segment of intestine in which the polyp is found. However, polyps in the colon in this syndrome do not necessarily have a very muscular stroma[6,19,37,41] and the diagnosis of hamartoma must then depend largely on the presence of a normal colonic mucosa. In our experience, the epithelium is not always uniformly normal and may include areas of a single cell type or areas with a pallisaded epithelium identical to that of the ordinary adenomatous polyp (Petrelli and Reid, unpublished observations). Some tumors originally interpreted as adenomas or villous tumors were later reinterpreted as hamartomas when it was realized that the patient had the Peutz-Jeghers syndrome.[44,45] There is one report of a

Table 3. Cases of Peutz-Jeghers Syndrome with Gastrointestinal Carcinoma and Metastases

Author	Sex	Age	Primary and Description of Spread
1. Freeman and Ravdin 1955[9]	M	35	Ileum: Died of metastatic cancer subsequent to report (Kutscher, et al[31])
2. Christiaens, et al 1959[38]	M	37	Stomach (probable): Abdominal wall 2 months postgastrectomy
3. Hermann and Saro 1961[39]	M	16	Rectum: Liver
4. Achord and Proctor 1963[40]	F	13	Stomach: Liver
5. Horn, et al 1963[41]	F	45	Stomach and duodenum: Disseminated
6. Kopylow, et al 1963[42]	M	30	Stomach: Nodes
7. Ficari and Cocchieri 1965[43]	M	40	Colon: Peritoneum and omentum
8. Reid 1965[44]	F	39	Duodenum: Nodes, heart
9. Warren, et al 1965[45]	F	37	Duodenum: Pancreas
10. Williams and Knudsen 1965[46]	F	52	Duodenum: Node
11. Payson and Moumgis 1967[47]	M	21	Antrum and duodenum: Nodes (Died within 1 year with involvement of pancreas and lungs.)
12. Gasser and Arquint 1969[48]	M	26	Duodenum: Liver
13. Altemeier 1969[49]	M	55	Colon: Metastatic invasive cancer
14. Mackman, et al 1969[50]	M	22	Jejunum: Abdominal incision scar (well 1972)
15. Moretti, et al 1969[51]	M	37	Small intestine: Liver
16. Strauch (personal communication) 1972	F	61	Antrum and duodenum: Liver, peritoneum

polyp with a uniform cell type in the small intestine.[44]

Since not all of the myoglandular polyps are clothed by normal mucosa, the theoretical immunity to neoplasia is invalid.

3. *Has carcinoma been demonstrated to arise in Peutz-Jeghers-type polyps?*

As noted, the original case reported by Peutz[12] includes a good description of in-situ carcinoma in a jejunal polyp. A more recent case concerns a 12-year-old girl with the diagnosis of adenocarcinoma in a polyp.[33] While the histologic description is certainly not that of a hamartoma, it is possible to question whether the lesion was an atypical invasive adenosis rather than a potentially metastasizing proliferation. In five cases, there is acceptable evidence of cancer in hamartomatous polyps.[26,37,41,46,51] In one, there was metastasis to a lymph node[46] and in another to the liver.[51] While an uncommon event particularly in relation to the total number of polyps usually present, the possibility of malignant transformation must be accepted.

4. *Is one particular segment of the intestine more at risk than another?*

Early suggestions that families afflicted with the Peutz-Jeghers syndrome had an abnormal incidence of carcinoma of the colon and rectum[7] have not been confirmed by more recent authors.[56] Of the 33 cases accepted as carcinoma in this review, 16 (49 percent) involved the colon and rectum, five (15 percent) the jejunum or ileum, four (12 percent) the duodenum, three (9 percent) the stomach and duodenum in continuity, and five (15 percent) the stomach. Among the 16 cases of metastasizing cancer, four (25 percent) occurred in the duodenum and a further three involved both the duodenum and stomach making a total of seven (or 44 percent).

The distribution of ordinary gastrointestinal carcinoma in the United States population is quite different, with 80 percent found in the colon and rectum, 16 percent in the stomach, and only 1 percent in the small intestine.[52] Cancers of the duodenum are even fewer and constitute approximately one-third of those of the small intestine.[57,58] It thus appears that in the Peutz-Jeghers syndrome metastasizing cancer is more likely to develop in the duodenum than in other parts of the intestine. Whether this is due to malignant change in polyps (which are less frequent in the duodenum[11] than in the small and large intestine) is not clear.

Summary

Among 492 cases of the Peutz-Jeghers syndrome reported through December 1972, sixteen (3.2 percent) have had metastasizing carcinoma and a further 17 (3.4 percent) have had locally invasive or in-situ cancer. Although no increased frequency can be established by statistical analysis, the relatively early age at which cancers have developed, the unusual proportion in the small intestine, and the unusual involvement of both antrum and duodenum in continuity, suggest that there is a small-but-real addition to the ordinary risk of malignancy. The polyps in the Peutz-Jeghers syndrome are predominantly hamartomas but may contain epithelium with the characteristics seen in ordinary adenomas. Malignant change in polyps has been established but is rare. The practical significance of these findings is that complete disregard for malignant change is unjustified; while overzealous surgical intervention remains unwarranted.

Acknowledgment: We appreciate the assistance in translation by Drs. B. Czarnetzki; H. B. Oey; J. Opplt; and A. Tomaru, and Messrs. A Selivaniv and F. James.

Note: A full list of references may be obtained from Dr. Reid or from *The Journal* office.

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Papillary Cystadenocarcinoma of the Pancreas

Joseph L. Bilton, M.D.;* Nadir D. Saddawi, M.D.; Krishna P. Saigal, M.D.; and Madhira D. Ram, M.D.

TRUE CYSTADENOCARCINOMAS of the pancreas are very rare and interesting lesions. Lichtenstein[1] was the first to describe this as a distinct entity separate from solid adenocarcinomas with epithelial lined cysts and from other cysts in association with carcinoma. The incidence of the lesion has been estimated to be .001 percent of all hospital admissions in two large series.[2,3] In a review of the subject in 1965, Becker et al,[4] could find only 65 well-documented cases in the literature. Because of the rarity, no single individual can obtain a large experience. We report a case of a papillary cystadenocarcinoma of the pancreas.

Case Report

This 58-year-old white woman was admitted in September 1971 with the chief complaint of chest pain radiating to the left shoulder for five days. The pain was described as sharp and severe. Movements and walking exaggerated the pain. She had frequent attacks of mild epigastric pain with a feeling of heaviness in her left upper abdomen. She denied any weight loss. Her appetite was good, and she had no nausea or vomiting. Bowel movements were normal. There was no history of fever. The patient was hypertensive and was on treatment with methyl dopa and diuretics. She underwent an appendectomy and removal of right ovarian cyst in 1950. The ovarian cyst was a benign serous cyst. In 1963 a muco-epidermoid carcinoma of the right submandibular salivary gland was excised and this was followed by radiation therapy. There was no evidence of recurrence up to the present admission. She gave a history suggestive of peptic ulceration and one episode of bleeding in 1963. The patient developed diabetes mellitus over the last four years, well controlled by diet and phenformin.

On physical examination, she was an obese woman in acute distress. The blood pressure was 210/100 mm Hg; pulse was 80 beats per minute and regular. There is a scar surrounded by pigmented area in the right submandibular region. Heart and lungs were within normal limits. Breasts were negative for masses. Abdominal examination revealed a scar of previous operation in the lower abdomen. The abdomen was soft, and not tender. A mass, 14 X 10 X 10 cm in size was noted in the epigastric area, more to the left of the midline. It was not tender, was firm, smooth surfaced, not pulsating, and not moving with respirations. Liver and spleen were not palpable.

Laboratory studies including hemogram, creatinine phosphokinase (CPK), serum glutamic oxaloacetic transaminase (SGOT), lactic dehydrogenase (LDH), blood urea nitrogen (BUN), creatinine, uric acid, total protein, serum bilirubin, calcium, and phosphorus, cholesterol, and serum amylase were all within normal limits. Urinalysis re-

The Authors

- **Dr. Bilton, who died August 8, 1972, was Director, Department of Surgery, Huron Road Hospital, Cleveland.**
- **Dr. Saddawi was formerly Chief Resident in Surgery, Huron Road Hospital.**
- **Dr. Saigal, Cleveland, is Pathologist, Huron Road Hospital.**
- **Dr. Ram, Cleveland, is Director, Department of Surgery, Huron Road Hospital; and Assistant Clinical Professor of Surgery, Case Western Reserve University School of Medicine.**

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Submitted August 27, 1973.

vealed a trace of albumin and was negative for glucose and sediment. Results of electrocardiogram and chest x-ray were normal. Barium enema revealed sigmoid diverticula. Intravenous pyelograph showed no evidence of intrinsic renal abnormality. Radiographs, however, suggested a possible retroperitoneal mass over the upper half of the left psoas, displacing the left kidney slightly downward and laterally. Barium studies of the upper gastrointestinal tract were strongly suggestive of a pancreatic cyst (Fig. 1). Oral cholecystogram showed a normal gallbladder. Celiac superior mesenteric arteriogram was attempted but was unsuccessful. Pancreatic scanning with Se^{75}-tagged selenomethionine indicated a lack of visualization of the body and tail of the pancreas, possibly the result of replacement of the pancreatic tissue (Fig. 2).

Hospital Course: At the conclusion of the study, the diagnosis of a pancreatic lesion was made. The patient underwent an exploratory laparotomy. All abdominal organs were within normal limits except for the pancreas which revealed a cystic mass occupying the tail as well as the distal two-thirds of the body. It measured 10 X 10 X 14 cm and the surface was smooth. The cyst was first aspirated and serous fluid was obtained. On opening the cyst, the cavity was found to be filled with papillary projections. Frozen-section biopsy revealed a papillary tumor. Distal pancreatectomy



Fig. 1. Lateral view of barium-filled stomach showing anterior displacement by a smooth mass.



Fig. 2. Hepatopancreatic scan. Lack of visualization of body and tail of pancreas.

with excision of the cyst as well as splenectomy was then carried out. Seven units of whole blood were given during the procedure. On the second postoperative day, the patient showed signs of hemorrhage and her abdomen was re-explored and a few bleeding mesenteric vessels were ligated. After that, the course of the patient was uneventful. Upper gastrointestinal studies were done on the 20th postoperative day and showed no abnormal findings. The patient was discharged in satisfactory condition.

Pathology Report: The cystic mass from the tail and body of pancreas weighed 226 gm and measured 10 X 10 X 14 cm. The external surface of the cyst was grayish-white and smooth. The wall of the cyst measured 0.1 cm in average thickness. The inner wall of the cyst was covered by multiple papillary processes, varying in diameter from 0.5 cm to 4 cm. These processes were grayish-white, soft, and necrotic (Fig. 3).

Microscopically, the fibrous wall of the cyst (Fig. 4) was lined by tall columnar cells, forming variable-sized glandular structures, and papillary infoldings. The cells lining the glands were tall and columnar with pink granular cytoplasm and showed stratification of nuclei. The nuclei were elongated with finely clumped chromatin. Mitotic figures and abnormal mitosis were seen with relative frequency. Focal areas of necrosis were noted in the tumor. Remnants of islets of Langerhans could be identified in the wall of the cyst (Fig. 5).

Follow-Up Notes: The patient did well for about six months and was then readmitted with epigastric pain and a mass 4 cm in diameter situated in the midline in the scar. After investigation, it was decided to excise the mass because of possible ulceration. At the time of excision, a limited exploration of the abdomen revealed the liver, omentum, and mesentery to be studded with secondary tumors. Histologically, the nodule was similar to the original lesion. She recovered well

from the operation, but she died two months later at home. Permission for autopsy was not obtained.

Discussion

Cystadenoma and its malignant variant, cystadenocarcinoma, are uncommon cystic tumors of the pancreas arising from the ductal epithelium.

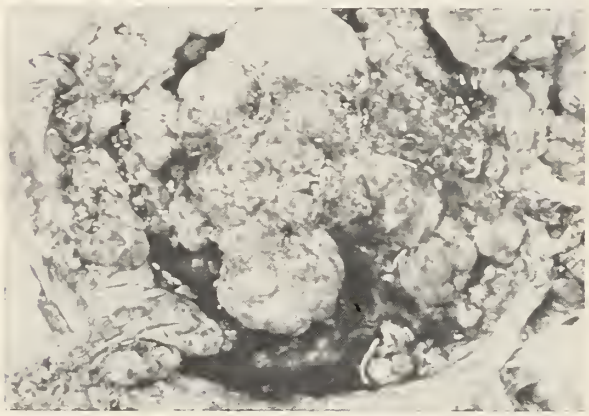


Fig. 3. Gross appearance of the cystic tumor laid open. Wall is thin and papillary masses can be seen projecting into cyst.

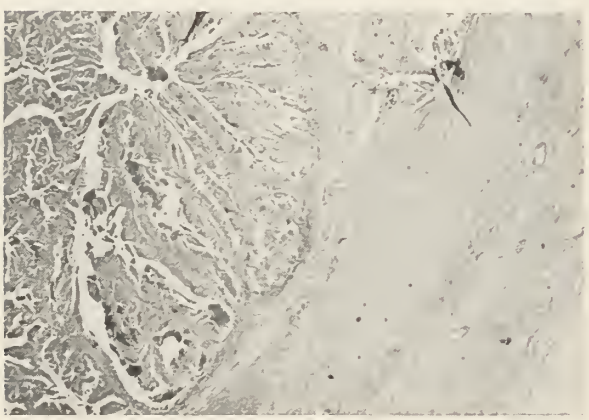


Fig. 4. Photomicrograph of the wall of the cyst.

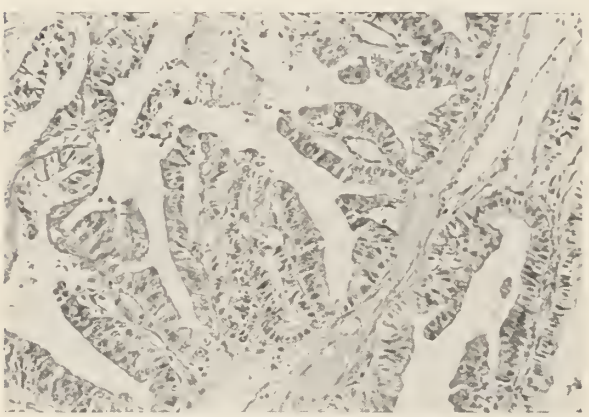


Fig. 5. Photomicrograph of tumor showing papillary process.

Cystadenocarcinoma can arise as transformation from previously benign cystadenoma.[1] The coexistence of cystadenoma and papillary cystadenocarcinoma in 6 of the 17 cases reported by Cullen, et al[2] lends further support to this concept.

Among the documented cases of cystadenocarcinoma including ours, the majority involved the body and tail of the gland. The lesion has been noted predominantly in the female. Seventy percent of the patients presented with mild-to-severe epigastric pain radiating to the back. Epigastric mass was present in 75 percent of the reported cases. Weight loss was noted in 50 percent of them. Diabetes mellitus was reported to be present in 18 percent. Other uncommon manifestations were jaundice, bowel obstruction, ascites, and gastrointestinal (G.I.) bleeding. The diagnosis is to be made by the presence of a pancreatic mass and the absence of history of pancreatitis, trauma, alcoholism, or cholelithiasis. The nature of the mass in the epigastric region may be revealed by roentgenographic studies of the upper G.I. tract, pancreatic scanning, and selective angiography.

Total excision of the cystic lesion with a margin of normal pancreas is the recommended treatment for lesions of the body and the tail of the pancreas. This was feasible in this patient and was done. Local invasion of the stomach, colon, or small bowel does not preclude resection. Ascites is not a contraindication for surgery. When the tumor involves the head of the pancreas, duodenopancreatectomy should be done, provided there are no local or distant metastases and the portal vein and the superior mesenteric vessels are not involved in the cancerous mass. Drainage procedures are not only inadequate, but they also promote local spread in cases with cystadenocarcinoma of the pancreas.[5] The tumors are very vascular and surgical removal is associated with profuse bleeding. Occasionally, the tumor leads rapidly to death, but more often the course is slowly progressive with a tendency for the tumor to remain localized for long periods after attaining a large size. The lesion is considered more amenable to surgical treatment than is the conventional solid pancreatic carcinoma. Thirty-eight percent of Warren and Hardy's patients[5] lived five years and 23 percent lived for ten years. The value of radiotherapy and chemotherapy in the management of these tumors is not known.

In view of the extreme rarity of the lesion, there is a need for adequate documentation of this lesion so that the natural history of the tumor can be better understood.

Summary

A 58-year-old woman presented with a short history of epigastric pain and, on investigation, was

found to have a pancreatic mass. Exploration of the abdomen revealed a papillary cystadenocarcinoma of the body and tail of the pancreas and distal pancreatectomy was done. She survived for eight months after surgery. A review of the literature reveals that the lesion is very rare and surgical treatment offers the best results.

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The Nontoxic Edema of Pregnancy

Melvern A. Ayers, M.D.

THE EDEMA of pregnancy *not* associated with toxemia has many clinical interpretations. Frequently seen, the edema is treated in various ways by different physicians. The following questions about the nontoxemic edema of pregnancy may be asked. How many pregnant ladies have edema? Is it persistent or intermittent? What are the relationships to weight gain, or to rate of weight gain, or to toxemia? What does it mean to the baby? What are the causes? What are the treatments?

Case Example

Let us consider an average healthy 5 foot 4 inch Ohioan, five months pregnant, during a typical work day in August. This lady, a laboratory assistant, had a prepregnant weight of 55.8 kg (123 lb). Physical examination revealed no varicose veins. She related no history of phlebitis, renal disease, or other complications and was found to be in good general health. Her weight and leg measurements were taken upon arising from and on retiring to bed. Her weight from morning to night increased from 60.4 kg (133 lb) to 61.1 kg (135 lb), her thigh measurements increased from 45 cm to 46 cm, her calf from 35 cm to 36 cm, and her instep stayed at 22 cm. On the next Monday, after a *week-end of rest at home,* the increase in leg measurements was greater—her thigh from 44 cm to 46-½ cm, her calf from 34 to 36 cm, and her instep from 21 to 22 cm. In September, this patient left the laboratory and assumed the daily chores of a housewife. A similar pattern of leg swelling was observed on busy days, shopping, canning peaches, but on lazy days when she rested with leg elevation, her weight would increase but her thigh measurements stayed at 45 cm, her calf at 34 cm, and her instep at 21 cm, despite a 9-kg (2-lb) or 11-kg (2-½-lb) weight gain, or should I say weight fluctuation. Similar observations were made in several other prenatal patients, and not one *decreased* her leg measurements from morning to evening.

Literature Review

If we change our perspective from one pregnant Ohio housewife to a large group assessment in the literature, one must consider the outstanding article by Thomson, Hytten, and Billewicz,[1] who reviewed the records of over 24,000 women from 1950 to 1959. From the records they classified the women as:

(a) those who had no edema;
(b) those with edema of the legs;
(c) those with edema elsewhere than in the legs; and
(d) those who were normotensive or hypertensive.

In the normotensive women, leg edema increased with age, being present in 14 percent of those under 20 years of age and in 29 percent of those over 30 years. Preliminary evidence suggested that women who had been edematous in one pregnancy were twice as likely to develop edema in a subsequent pregnancy as those who did not have this sign. Women too heavy for their height at 20 weeks of pregnancy were more likely to have edema, usually of the generalized type, than those

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Submitted June 13, 1973.

of average weight or less. If overweight women gained weight at the high rate of .54 kg (1.2 lb) or more per week, there was a 24 percent chance that they would have leg edema and a 42 percent chance that they would develop edema other than in the legs. When the rate of weight gain was less, so was the chance of developing edema. These were the changes found in normotensive women. In hypertensive women (diastolic over 90 mm Hg), the incidence of edema was even more likely when there was proteinuria as well.

In the overall group, edema of some kind was present in 35 percent of normotensive women, 65 percent of hypertensive, and 85 percent of those with preeclampsia as defined. A considerable number of women did not have clinically recognizable edema even when they had hypertension with or without proteinuria. This reminded me of my resident days when we were warned to watch out for the "dry toxemia" patient. In reviewing the literature, I could find no reports that the nontoxemic edema of pregnancy is associated with fetal or newborn edema, nor have I clinically observed this except in a severe Rh sensitization where hydrops fetalis and massive maternal edema can occur, including the sacral area. In Thomson's[1] study, women with edema tended to have larger babies than those who did not have edema, though the difference was only 0.08 kg (0.17 lb). The prematurity rate, on the average, was less when there was edema, especially of the legs, while the perinatal mortality rate was the same whether there was edema or not. The conclusion the authors reach is that "edema, in the absence of other evidence of pre-eclampsia, is associated with a slight advantage in terms of birth weight and incidence of low birth weight, and is not associated with any disadvantage in terms of perinatal mortality. To that extent, it is possible to affirm that edema in pregnancy is not necessarily harmful and unphysiological."

Causes of leg edema can be explained by the familiar concept of edema as free extracellular water with the same composition as an ultrafiltrate of plasma. Increased intravenous pressure caused by the enlarging uterus in the pelvis, together with a reduction of intravascular colloid osmotic pressure could account for the increased passage of water through the capillaries to the interstitial space of the lower limbs. By rest in bed, the mechanical pressures are reduced, fluid rejoins the circulation, a diuresis follows, and the edema becomes less. As Hytten[2] has pointed out, the troublesome nocturia which afflicts some women in late pregnancy is probably due to the excretion of water which has lain in the extracellular tissue of the legs during the day.

Generalized edema is a different matter and perhaps can be explained by changes in the ground substance which contains much of the body extracellular water by some loose form of chemical combination. Some ground-substance components in various organs and tissues (for example, the sex skin of monkeys and the rooster's comb) are known to be affected by hormones, and a chemical change brought about by estrogen makes the ground substance more hygroscopic.[3] The practical implications of this "softening up" of ground substance in pregnancy are obvious—the cervix becomes increasingly soft and distensible, the pelvic joints more mobile, and the nipples pull more freely away from the breasts and the cheeks may swell.

Beyond a certain limit, this collection of water in the ground substance of the extensive fibrous-tissue layers in the skin becomes apparent as edema. Presumably these changes take place in all pregnant women but not all women develop this type of clinical edema. Some women gain excessive water yet have no edema, and others gain little but show generalized edema. Changes in intracellular water are not completely understood. We do know that the obese patient will gain less dry weight and more body water, while the non-obese patient will gain relatively more dry weight and less body water.

Treatment

Many obstetricians today do treat leg edema with diuretics, salt restriction, diet restriction, elevation, etc. Doctor Greenhill, in the textbook, *Obstetrics*, states: "moderate swelling of the feet and ankles is common, especially during hot weather. Pronounced swelling of the feet and ankles or other parts of the body should arouse a suspicion of toxemia. However, mild edema unassociated with other symptoms, such as severe headache, stubborn constipation, excessive gain in weight and proteinuria, is of no special significance." Also, with recent studies in the relationship of maternal nutritional deprivation and fetal outcome, perhaps too rigid dietary restrictions for edema may harm, more than help, the fetus. Leg edema can be decreased by the use of pressure-gradient leotards.

Summary

Nontoxemic edema of pregnancy is most commonly physiologic, probably will not cause maternal or fetal damage of consequence, and does not require intensive treatment.

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The Cost of Getting the Job Done

FIRST OF ALL, let me point out that the Medical Profession is a vital link in the Volunteer Segment—that vast body of men and women who volunteer their services toward strengthening the American way of life. We're referring here, of course, to the Medical Profession as an organized



Oscar W. Clarke, M.D.
President, Ohio State Medical Association

body. Early efforts were made to organize the Medical Profession under an "official" umbrella, but the Ohio State Medical Society (now the Association) emerged a purely voluntary organization of physicians.

As life became more complicated, a more closely knit organization evolved. Physicians found they could not devote enough time to the business and socioeconomic affairs demanded of the Medical Profession. The result was the development of a staff of people who operate under the direction of the House of Delegates and The Council, who in turn are advised by numerous committees composed of physicians in every branch of the profession.

The Medical Profession comprises less than two-tenths of one percent of the population, yet the profession can flex its muscles with labor, big business, and all of the other forces that are influencing government and society. It owes its strength to two main factors. First, there is the volunteer physician who takes the everyday tasks in their order, and who faces up to the "mission impossible" as necessity demands. Second is the professional organization—a staff of dedicated people who know every nut and bolt of the vast medical-health complex.

With the encroachment of government into the medical-health field, more and more responsibility is thrown on medical organization to maintain the free practice of medicine and to protect the public from an overabundance of "official" medical and health proposals. As the threat to medicine and to the public's health becomes stronger, organized medicine cannot afford to stand still, much less go backwards. With the cost of doing business on the rise, the Association cannot do the same job with the same number of dollars.

We desperately need at least two field men in Ohio, men who can spend virtually all of their time working with County Medical Societies and helping "pull it all together." Ohio's strength is in its well-organized County Medical Societies, but many of its smaller Societies do not have the help to deal with the professional know-how of this complex age.

We desperately need at least two men to work with the Ohio General Assembly, where bills with medical-health implications are introduced by the dozens. The job can no longer be done as a "collateral duty" assignment to full-time duty on the OSMA headquarters staff. These men must be in the House and Senate continuously, not dividing their time between organization duties and the Legislature.

Last year the Legislature was in session almost constantly, and it looks like another long session this year. This is in contrast to the former two- or three-month sessions every second year. Legislators must be made aware that the Ohio State Medical Association is ever ready and able to give advice or to offer expert testimony when medical and health matters are at stake. Physicians of Ohio must be alerted when either good or bad legislation is pending.

With the ever increasing encroachment of the government into the practice of medicine, legal issues are becoming more complex and legal entanglements more numerous. Numerous court actions will be necessary to preserve the rights of Ohio physicians. Association officers and staff members must rely more and more on legal counsel. Court procedures are expensive and require special counsel. Funds are not available at this time for more than a minimum of legal counsel.

Printing and paper are essential elements in communication between the OSMA and its more than ten thousand members. Costs in both of these fields is skyrocketing. Costs of *The Journal*, first line of communication between the Association and

Ohio physicians, has gone up. Ironically, advertising on which *The Journal* formerly relied for a large part of its income has fallen off. The Association cannot afford to curtail communications in this age of lightning-quick activities and changes. These considerations mean budgeting more for communications purposes.

Liaison must be maintained with government agencies with which physicians deal—Medicare, Medicaid, the Industrial Commission, Veterans Administration, etc. This requires considerable time of staff members as well as physicians' time to maintain professional contacts.

The Association has expanded its personal services to members considerably. The various group insurance plans available to physicians through sponsorship of OSMA take dedicated attention of staff members.

Inflation has hit almost every phase of Association work. Cost-of-living increases have forced salaries of employees up. Fringe benefits for employees, especially in such fields as the increased employer's share of Social Security taxes, have gone up.

Meeting costs have gone up. Cost of meeting space, meals, travel expenses such as gasoline, have all gone up.

All of these items are mere elements in an organization that has evolved out of necessity. If the Medical Profession relaxes its influence over medical and health matters, the do-gooders will take over. Political expediency will shove statesmanship aside and the medical profession as well as the American people will be at the mercy of a vast bureaucracy.

The Council of the Ohio State Medical Association has proposed to the House of Delegates that the annual dues of the Ohio State Medical Association be set at $110 beginning January 1, 1975. This figure will enable the Association to stay ahead of its current budget and add the needed elements before mentioned.

We must modernize our Association to cope with the times.

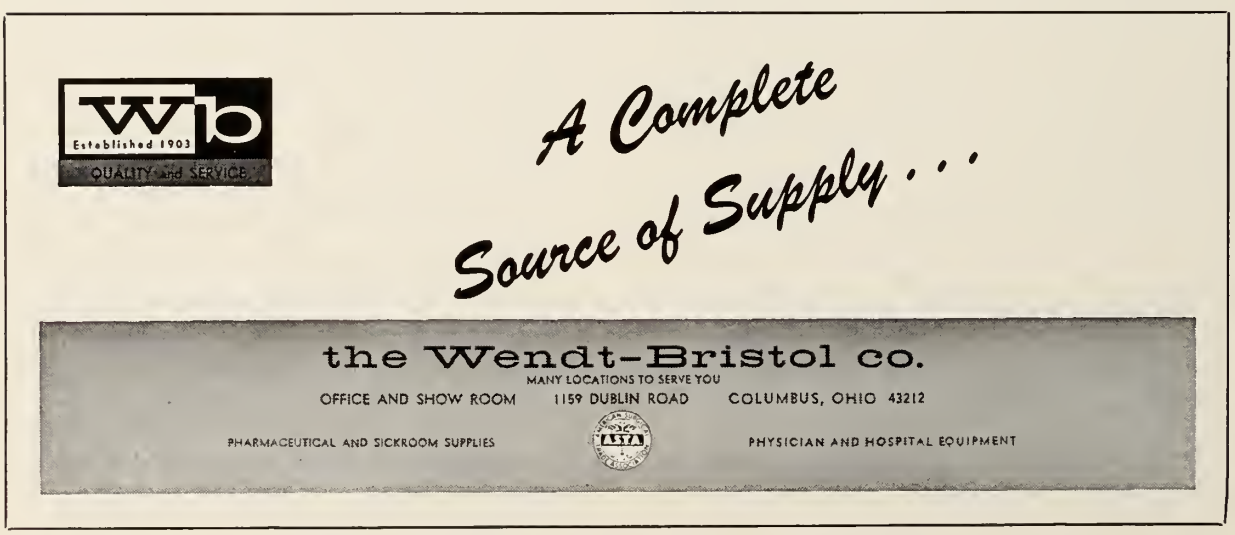
Oscar W. Clarke, M.D.
President,
Ohio State Medical Association

27th National Rural Health Conference Scheduled in Detroit

The 27th National Conference on Rural Health will be held at the Detroit Hilton Hotel, Detroit, Mich., April 25-26, under sponsorship of the American Medical Association's Council on Rural Health, in cooperation with a number of other organizations interested in this subject.

Robert E. Reiheld, M.D., Orrville, Ohio is chairman of the Council on Rural Health, and will have a leading role in the conference.

Registration fee of $25 includes a luncheon and evening reception. Hotel reservations should be made with the Detroit Hilton, Grand Circus Park at Washington Blvd., Detroit, Mich. 48231, or with the hotel of choice.





Maurice F. Lieber, M.D.

Candidate for the Office of President-Elect

IN ACCORDANCE WITH Section 3 of Chapter 5 of the OSMA Bylaws, the following nomination of a candidate for the office of President-Elect of the Ohio State Medical Association has been filed with the Executive Director 60 days prior to the meeting of the House of Delegates at which the election is to take place:

The Stark County Medical Society

Canton, Ohio
November, 29, 1973

Mr. Hart F. Page, Executive Director
Ohio State Medical Association
17 South High Street
Columbus, Ohio 43215

Dear Mr. Page:

By constitutional privilege, we are pleased to nominate Maurice F. Lieber, M.D., the Sixth District Councilor, as a candidate for the office of President-Elect of the Ohio State Medical Association.

Dr. Maurice F. Lieber is qualified by membership in good standing in the Stark County Medical Society, the Ohio State Medical Association and the American Medical Association.

Respectfully submitted

Robert K. Gardner, M.D.
President

E. J. Davis, M.D.
Delegate

Biographical Sketch

MAURICE FRANKLIN LIEBER, M.D.

Dr. Lieber was born in Canton, Ohio, on August 12, 1911. His parents were William Grant and Mary Louise Lieber. He attended the public schools of Canton and graduated from Canton McKinley High School. He then went to Washington and Jefferson College, where he received an A.B. degree in 1934, and to the School of Medicine, Johns Hopkins University, where he graduated in Medicine in 1938.

His surgical training was taken at the Johns Hopkins Hospital and the Union Memorial Hospital, in Baltimore, Maryland.

In 1941 he entered the military service and became Chief of Surgery of the 10th Station Hospital attaining the rank of Colonel. Following discharge from the Army he resumed his surgical training.

He became a Fellow of the American College of Surgeons in 1947 and later that year entered the private practice of surgery in his native city, Canton, and has been there in solo practice ever since. He has been active in industrial surgery having been associated with the Republic Steel and the Diebold Corporations.

Dr. Lieber is married to the former Doreen Godrey, of Liverpool, England, and the couple has two daughters, Diane Lieber Spera, who is presently employed in journalism in Denver, Colorado, and Jennifer Anne Lieber, a third year student at Mount Union College.

Dr. Lieber has been Chief of Surgery of the Aultman Hospital of Canton and is on the Courtesy Staff of the Timken Mercy Hospital and the Molly Stark Hospital, also of Canton. He was president of the Aultman Hospital Medical Staff, and president of the Stark County Medical Society. He has served on many committees of that organization and has been a long time member of the Council of his county society.

He has served as Councilor for the Sixth Councilor District since 1969, is now in his third consecutive term in that office, and has had varied assignments with the Ohio State Medical Association. He has been a long-time member of the Legislative Committee, is a past chairman of the Committee on Nursing, and is currently chairman of the Committee on Private Practice, an office he has held since the committee was first formed. He is chairman of the Auditing and Appropriations Committee, is a member of the OSMA Building Committee and the Ohio Medical Indemnity Liaison Committee, and has served on a number of Ad Hoc committees.

Dr. Lieber is a member of the United Presbyterian Church. He has been affiliated with the Canton Lodge Number 60 and other Masonic bodies including the Scottish Rite, 32nd Degree, Valley of Canton, and the Tadmor Shrine. He is actively associated with the Health Foundation Board of the Canton United Fund. Other civic

organizations he is or has been connected with include the Chamber of Commerce, the Stark County Historical Society, the Canton Library, the Player's Guild and the Y.M.C.A. He belongs to the Canton Club. For many years he was the team physician of the Canton McKinley High School football team.

Dr. Lieber, in addition to memberships in the Stark County Medical Society, Ohio State Medical Association and American Medical Association, is a Fellow of the American College of Surgeons, a member of the Ohio Chapter, American College of Surgeons, the Johns Hopkins Surgical Association and the Cleveland Surgical Society.

A participating speaker for many organizations, he currently is an active member of the AMA Speakers Bureau and the OSMA Speakers Bureau. He is an experienced witness before legislative committees.

An avid golfer, Dr. Lieber now confines his links activities largely to senior events. He is a member of the Congress Lake Club, the Ohio Medical Golfers Association and various seniors' organizations.

Chicago Physician to Head OSU Ob-Gyn Service

The head of obstetrics and gynecology at the University of Chicago, Dr. Frederick P. Zuspan, will become chairman of that department in the Ohio State University College of Medicine.

Ohio State's Board of Trustees on February 1 approved a recommendation for the appointment of Dr. Zuspan, effective next December 1.

Dr. Garth F. Essig, assistant professor, has been serving as acting chairman since last July.

Dr. Zuspan, 52, has been DeLee Professor and chairman of obstetrics and gynecology at Chicago since 1966 and is also obstetrician-gynecologist-in-chief at Chicago Lying-in Hospital. He is president of the American Academy of Reproductive Medicine, a director and examiner of the American Board of Obstetrics and Gynecology, and a past president of the Association of Professors of Gynecology and Obstetrics. Dr. Zuspan was born at Richwood, Ohio.

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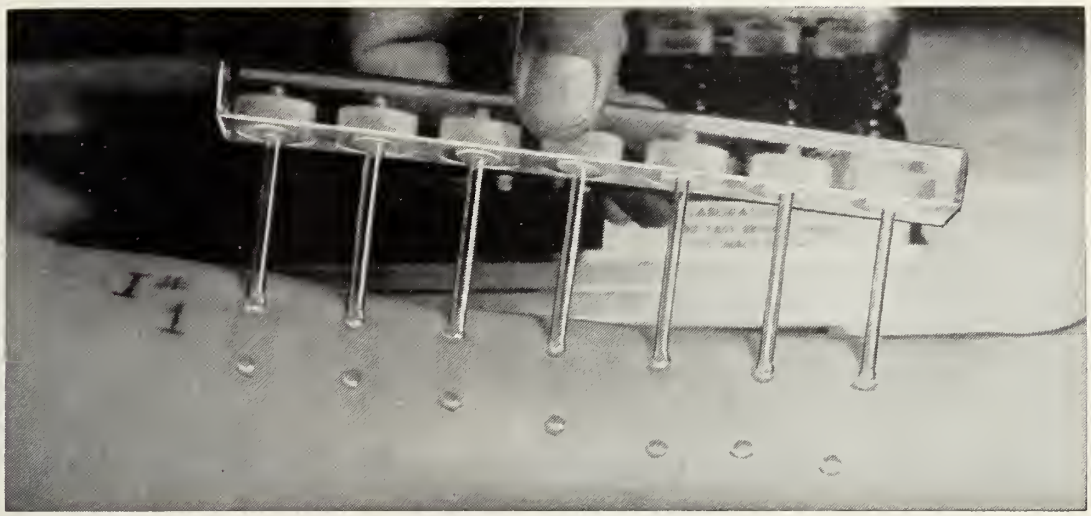
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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964

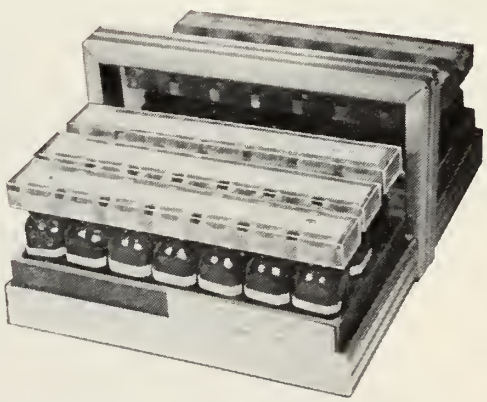
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Two More Worthy Medical Students Sought for OSMA Family Practice Scholarships

APPLICATIONS FOR THE Ohio State Medical Association's two annual family practice scholarships are now being received, Dr. Oscar W. Clarke, Gallipolis, OSMA President, announced.

"The $2,000 scholarships are for the purpose of stimulating, among medical students, interest in practicing family medicine in Ohio," Dr. Clarke said.

Candidates are required to be Ohio residents, to have completed their premedical education, and to have been accepted by a medical school. Application must be made in the year of entering medical school—but prior to beginning medical studies.

Candidates are judged on the basis of interest in family practice, leadership, interest in community activities and organizations, intelligence, maturity, scholastic ability, and need.

Administered by the OSMA Family Practice Scholarship Subcommittee, the program pays each recipient from a four-year medical school $500 annually. Payment dates are arranged with students enrolled in three-year medical schools. The award is paid directly to the winners.

Application forms may be obtained from the Family Practice Scholarship Subcommittee, Ohio State Medical Association, 17 South High Street, Columbus, Ohio 43215. Completed applications must be in the OSMA offices no later than June 1, 1974. Also, all candidates will be required to attend a special luncheon sponsored by the Family Practice Scholarship Subcommittee on Wednesday, June 12, 1974 in Columbus.

Recipients of the 1973 scholarships were Messrs. Christopher Demas, of Reynoldsburg, now attending The Ohio State University College of Medicine, and Donald J. Kennedy, of Athens, now attending the University of Cincinnati College of Medicine.

Other medical students on OSMA Family Practice Scholarships include Mrs. Phyllis A. Hutson, of Maple Heights, Case Western Reserve School of Medicine, Cleveland; Carl S. Wehri, Cloverdale, the Ohio State University College of Medicine; Donald M. Miller, Upper Sandusky, Medical College of Ohio at Toledo; Albert J. Weisbrot, Cincinnati, University of Cincinnati College of Medicine; John E. Pappas, Cuyahoga Falls, Temple University School of Medicine, and John H. Surry, Youngstown, St. Louis University College of Medicine.

This marks the 26th year for the OSMA scholarship program.



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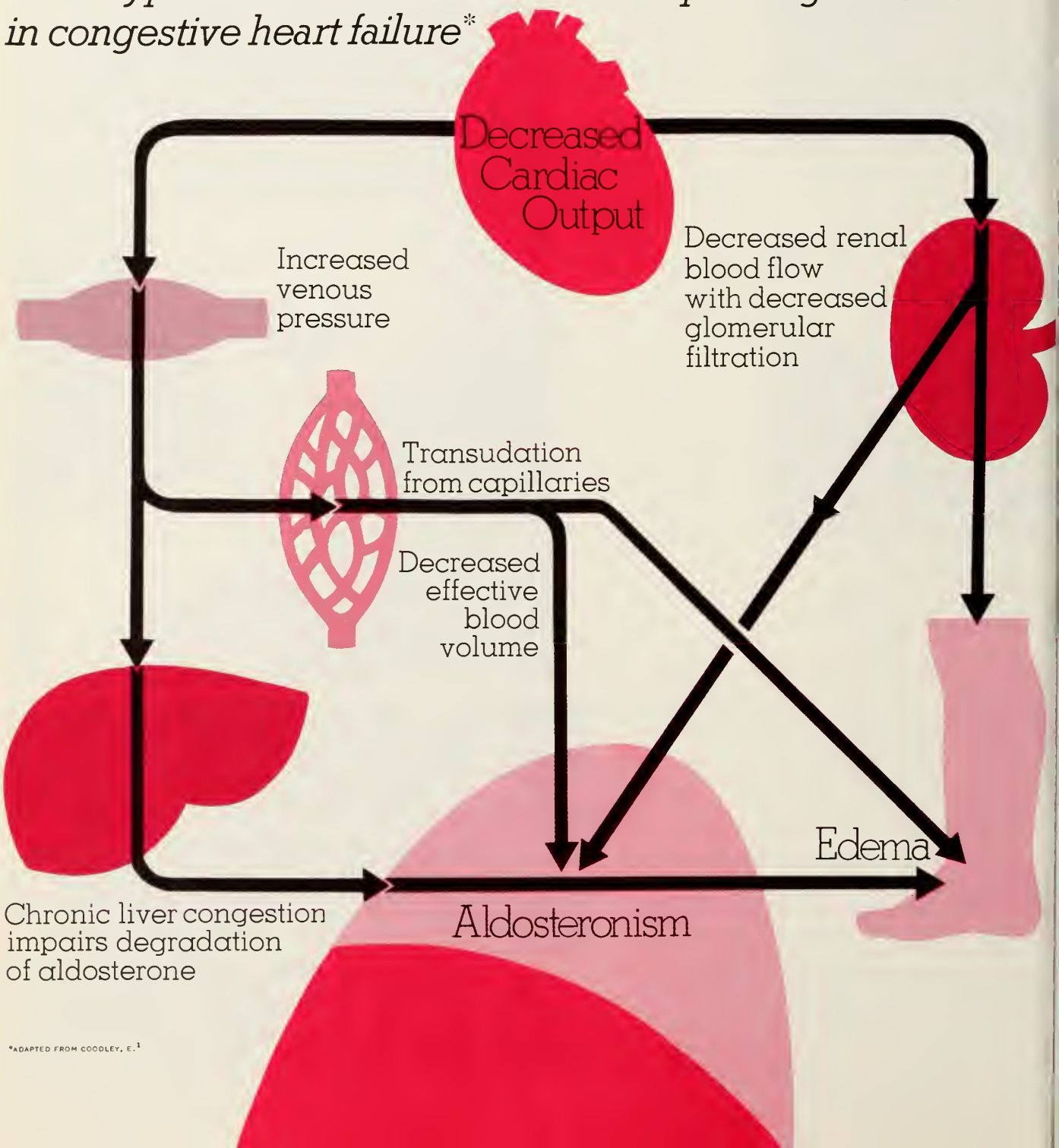
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*How hyperaldosteronism leads to and prolongs edema in congestive heart failure**



*ADAPTED FROM COODLEY, E.[1]

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- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide
- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For **edema, ascites** or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

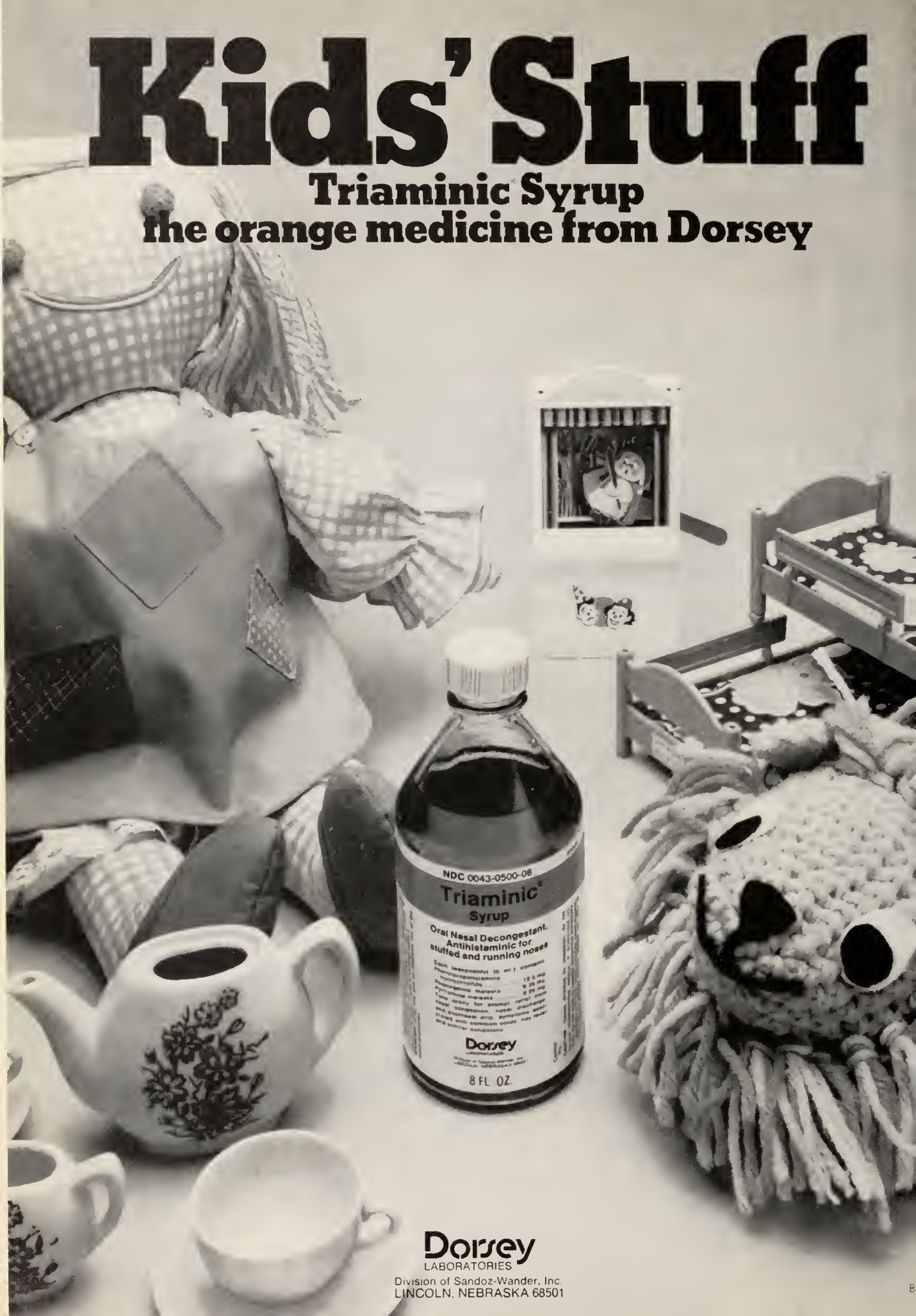
References: 1. Coodley, E.: Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Louler, D. P.: Am. J. Med. 53 673-684 (Nov.) 1972.

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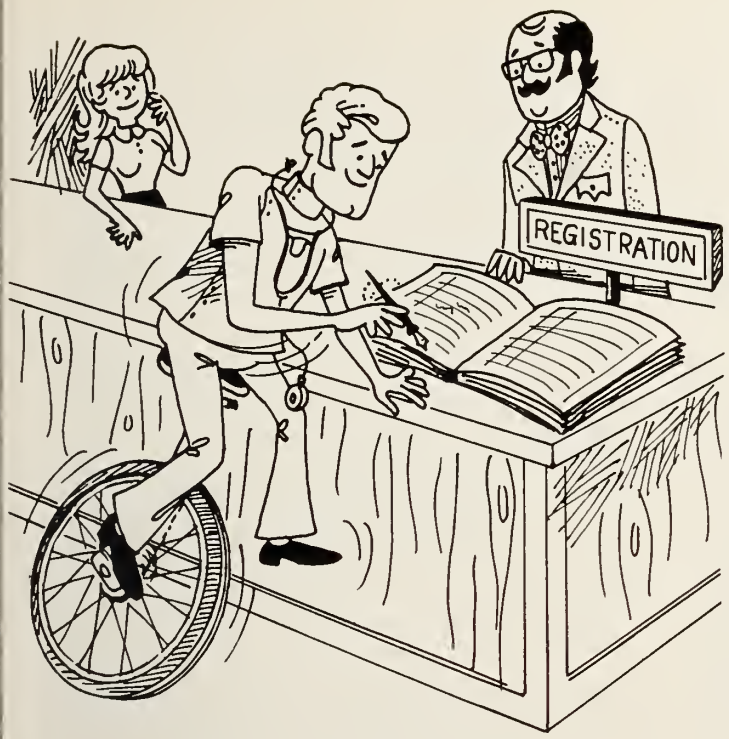
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MAY 12-15 Sheraton-Cleveland Hotel 1974 OSMA Annual Meeting

THE Committee on Scientific Work has been busy arranging a full program of events, due to space, only a few of the many excellent programs are printed in The Journal but it is safe to say that virtually every specialty can find a program of benefit to them. Remember this program was designed **by physicians for physicians.** Many, many hours of program planning has gone into the 1974 Annual Meeting—support the many programs with your attendance.

For many years the chief complaint from our members has been . . . I would visit the exhibits but they are never open when I am not tied up in a meeting, etc. Not so this year! For the first time, exhibits will be open Monday evening, May 13 from 5:30 p.m.-8:00 p.m. in the Grand Ballroom, North, South and the Sheraton Hall as well as the Balcony. The ART SHOW under the Chairmanship of DR. VICTOR C. LAUGHLIN will be open for viewing on Monday evening, as well as Tuesday, May 14 and Wednesday, May 15 from 9:00 a.m.-4:30 p.m. SUPPORT THE EXHIBITORS . . . remember they play a very important and significant role in our Annual Meeting.

Remember your reservations for "OSMA'S OLDE but GOODE NIGHT" which promises to be an evening of nostalgia. Elsewhere in this issue is a reservation form for this event as well as the OMPAC LUNCHEON, Speaker: OTIS BOWEN, M.D., Governor, State of Indiana.

MONDAY, MAY 13

9:00 a.m. (All Day)
Whitehall Room, Mezzanine Floor

VASCULAR DISEASES: FROM INFANCY TO OLD AGE

Presiding: Howard S. Van Ordstrand, M.D., Member, OSMA Committee on Scientific Work; President, American College of Chest Physicians

Symposia and Panels

9:00 a.m. **Clues to Vascular Diseases at All Ages**

The Significance of Bruits — Walter H. Pritchard, M.D., Ergyl J. Beams Professor of Medicine, School of Medicine, and Chief of Staff, University Hospitals, Case Western Reserve University, Cleveland.

Other Clues — Jess R. Young, M.D., Department of Peripheral Vascular Disease, Cleveland Clinic.

What Can the Radiologist Contribute?— Thomas F. Meaney, M.D., Chairman, Division of Radiology, Cleveland Clinic.

9:30 a.m. Question and Answer Panel of above participants

10:30 a.m. Intermission

10:45 a.m. **Hyperlipidemias of all Ages**

As They Present Clinically — Victor G. deWolfe, M.D., Head, Department of Peripheral Vascular Disease, Cleveland Clinic.

Gastrointestinal Manifestations—Eugene I. Winkelman, M.D., Department of Gastroenterology, Cleveland Clinic.

The Dietary Management — Helen Brown, Ph.D., Emeritus Consultant, Research Division, Cleveland Clinic.

11:15 a.m. Question and Answer Panel of above participants

1:30 p.m. **Hypertension 1974**

Detection and Management in Childhood — Jennifer M. H. Loggie, M.D., Children's Hospital Research Foundation, Cincinnati.

Radiologic Findings in the Young — Margaret G. Zelch, M.D., Department of Radiology, Cleveland Clinic.

The Contribution of Hemodynamics and Volume Studies to Treatment — Robert C. Tarazi, M.D., Research Division, Cleveland Clinic.

2:00 p.m. Question and Answer Panel of above participants

2:45 p.m. Intermission

3:00 p.m. **Cerebrovascular Insufficiency**
Moderator: John E. Albers, M.D., Cincinnati, Member, OSMA Committee on Scientific Work.

What Are TIAs — Edward L. Westbrook, M.D., Department of Neurology, Cleveland Clinic.

The EMI Scan and Its Diagnostic Value in Strokes — James V. Zelch, M.D., Department of Radiology, Cleveland Clinic.

When Is Angiography and Surgery Indicated in Extra-Cranial Vascular Disease? — Edwin G. Beven, M.D., Head, Department of Vascular Surgery, Cleveland Clinic.

3:30 p.m. Question and Answer Panel of above participants.

TUESDAY, MAY 14

CHEST PHYSICIANS

12:00 Noon

Luncheon and Business Meeting, Ohio Society of Thoracic Surgeons and Ohio Chapter, American College of Chest Physicians. Lewis Room, Lobby Floor.

HEART AND LUNG DAY

9:00 a.m. (All Day)
Whitehall Room, Mezzanine Floor

Program sponsored by the Ohio Chapter, American College of Chest Physicians and the Ohio Society of Thoracic Surgeons.

PROGRAM

Presiding: James W. Kilman, M.D., Columbus, President, Ohio Chapter, American College of Chest Physicians

Moderator: Norman Baker, M.D., Columbus, Ohio Society of Thoracic Surgeons.

9:00 a.m. **New Procedures for Old Coronary Arteries** — Charles V. Meckstroth, M.D., Ohio State University Hospitals, Columbus.

9:20 a.m. **Development of Mitral Valve Prostheses** — William Blakemore, M.D., Medical College of Ohio, Toledo.

9:40 a.m. **Sarcoidosis: Some Uncommon Features** — Yash Kataria, M.D., Ohio State University Hospitals, Columbus.

10:00 a.m. **Surgery for Complications of Coronary Artery Disease** — John B. Flege, Jr., M.D., Director, Department of Cardiac Surgery, The Christ Hospital, Cincinnati.

10:20 a.m. Break for Tour of Exhibits

10:40 a.m. **Cardiac Surgery and Severely Impaired Left Ventricular Function** — John S. Vasko, M.D., Ohio State University Hospitals, Columbus.

11:00 a.m. **Long Term Followup of the Correction of Tetralogy of Fallot**—J. Tracy Schreiber, M.D., Christian Holmes Hospital, Cincinnati.

11:20 a.m. **Recent Advances in Cystic Fibrosis**—Gordon Young, M.D., The Columbus Children's Hospital, Columbus.

11:40 a.m. **Coronary Artery Surgery Without Cardiopulmonary Bypass** — Jay Ankeney, M.D., University Hospitals, Cleveland.

12:00 Noon Luncheon and Business Meeting
Members and Invited Guests
Presiding: James W. Kilman, M.D.,

President, Ohio Chapter, American College of Chest Physicians.

Speaker: Howard Van Ordstrand, M.D., National President, American College of Chest Physicians

Presentation: **First Annual Howard Van Ordstrand Award**

AFTERNOON PROGRAM

Presiding: Barney M. Wisinger, M.D., President-Elect, Ohio Chapter, American College of Chest Physicians.

1:30 p.m. **Howard Van Ordstrand Award Paper** — R. Donald Woodson, M.D., Medical College of Ohio, Toledo.

1:50 p.m. **Long Term Followup of Surgery for Cancer of the Lung** — Karl P. Klassen, M.D., Ohio State University Hospitals, Columbus.

2:10 p.m. **Newer Diagnostic Methods in Pulmonary Disease** — John Prior, M.D., Ohio State University Hospitals, Columbus.

2:30 p.m. **New Diagnostic Methods for Congenital Heart Disease** — Jerome Liebman, M.D., Professor of Pediatrics, Case Western Reserve University School of Medicine, Cleveland.

(Continued on Next Page)

HEART AND LUNG DAY *(Contd.)*

2:50 p.m. **The Calcific Mitral Valve Complex**— Charles Wooley, M.D., Ohio State University Hospitals, Columbus.

3:10 p.m. Coffee Break

3:30 p.m. **Minimal Blood for Open-Heart Surgery** — Richard A. DeWall, M.D., Cox Heart Institute, Kettering.

3:50 p.m. **The Significance of Black Lung Disease Legislation to the Practicing Physician** — Stuart M. Brooks, M.D., University of Cincinnati Medical Center, Cincinnati.

4:10 p.m. **Current Uses of Hyperbaric Oxygen Therapy** — R. Donald Woodson, M.D., Medical College of Ohio, Toledo.

TUESDAY, MAY 14

INTERRELATIONSHIPS OF E.N.T., ALLERGY, GP-FP

9:00 a.m.

Lewis Room, Lobby Floor

(Note: Program is acceptable for 2 prescribed hours by the American Academy of Family Physicians)

PROGRAM

Presiding Officer and Moderator: Robert S. Young, M.D., Johnstown Member, OSMA Committee on Scientific Work

9:00 a.m. **Allergy and the Family Practitioner** —Robert S. Young, M.D., Johnstown

9:10 a.m. **Otolaryngology Allergy** — William F. Licklider, M.D., Columbus

9:35 a.m. **The Scope of Allergy in Family Practice** — William F. Hughes M.D., Columbus

10:10 a.m. Panel Participants
Richard J. Wiseley, M.D., Toledo; Diplomate, American College of Physicians and American Board of Allergy and Immunology.

Richard H. Stahl, M.D., Cuyahoga Falls; President-Elect American Society of Ophthalmologic and Otolaryngologic Allergy

William F. Hughes, M.D., Assistant Clinical Professor of Medicine, Ohio State University, Columbus.

William F. Licklider, M.D., Otolaryngology, Columbus.

Robert S. Young, M.D., Family Practice, Johnstown

TUESDAY, MAY 14

9:30 a.m.-12:00 Noon

Terminal Room, Parlor Floor

Program sponsored by the Ohio Society of Internal Medicine and the Section on Internal Medicine.

PROGRAM

COMMUNICATION BETWEEN DOCTOR AND PATIENT

(Note: This panel type program will be acting out the part of the patient, physician and his office nurse in an everyday portrayal of communication between doctor and patient)

Panelist Participants

Jacob Hess, Jr., Attorney, Canton (Role of the Patient)

Donald G. Pocock, M.D., Massillon (Role of the Physician)

Mrs. Marian Bartolic, R.N., Massillon (Role of the office nurse)

Presentations followed by question and answer period.

Break for Tour of Exhibits

SPECIAL GUEST SPEAKER

11:00 a.m. **The Power of Wordless Persuasion** — Rev. William J. Beeners
Professor of Speech at Princeton
Princeton, New Jersey

Presiding: Donald Vidt, M.D., Cleveland
Moderator: Donald Pocock, M.D., Massillon

TUESDAY, MAY 14

PHYSICAL MEDICINE & REHABILITATION

1:30 p.m.

Mohawk Room, First Floor

Program sponsored by the OSMA Section on Physical Medicine and Rehabilitation; and Ohio Society of Physical Medicine and Rehabilitation.

Cardiac Rehabilitation:
Getting Down to Cases

1:30 p.m. Scientific Meeting
Presiding: Charles Long, II, M.D., Highland View Hospital, Cleveland

3:30-
4:30 p.m. Business Meeting.

TUESDAY, MAY 14

MEDICAL ASSISTANT'S PROGRAM

2:00 p.m.
Grand Ballroom Terrace, Parlor Floor
Program designed especially for the Medical Assistant entitled:

DOES *YOUR* OFFICE HAVE AN ENERGY CRISIS?

Welcome: Jack Schreiber, M.D., Canfield, Member, OSMA Committee on Scientific Work; and Alternate Delegate to the American Medical Association.

2:05 p.m. **OSMA — Where Do We Stand?**
Speaker: Oscar W. Clarke, M.D., President, Ohio State Medical Association, Gallipolis.

2:30 p.m. **How to Conserve YOUR Energy?**
(Panel Program)

- Space, equipment, reasonable hours, competitive wages, etc.
- Work routine and/or job organization
- Employer's cooperation, i.e., timeliness not just schedule but dictating, getting charges in, etc.
- Labor saving devices (pegboard, electric typewriter)
- Does your office need a Copying Machine?
- Are there enough girls in your office?

Panel Participants:

Francis O. Calkins, President, Professional Management of Cleveland.

Frederick T. Suppes, M.D., Family Practice, Cleveland

Mrs. Elizabeth Edwards, Medical Assistant, Eastlake

3:00 p.m. **Telephone — Wasted Energy?**
Speaker: Mrs. Mary Wilkin, Ohio Bell Telephone Co., Cleveland

3:30 p.m. **How to Conserve Your Doctor's Energy**

(Panel Program)

- Telephone Advice—how much?
- History and Physical exams by Assistants?
- What more can a medical assistant do?
- Employee on phone and at desk (greeting patients) does affect relationships and results.
- Adequate number of personnel.

Panel Participants:

Francis O. Calkins, President, Professional Management of Cleveland

W. J. Lewis, M.D., Family Practice, Dayton

Miss Laura L. Lockhart, Vice President, American Association of Medical Assistants, Inc., Akron

4:00 p.m. **How to Solve Your Energy Crisis with PR**

Speaker: Robert A. Lang, Ph.D., Executive Secretary, Cleveland Academy of Medicine.

4:25 p.m. Concluding Remarks — Jack Schreiber, M.D.

4:30 p.m. Adjournment

More Programs on Next Page

TUESDAY, MAY 14

E.N.T. AND OCCUPATIONAL MEDICINE

2:00 p.m.
Mohawk Room, First Floor

Program sponsored by the OSMA Sections on E.N.T., Occupational Medicine; and the Ohio Ear, Nose and Throat Society.

PANEL PROGRAM
OCCUPATIONAL HEARING PROBLEMS

Presiding: William J. Loeb, M.D., President, Ohio Society of Ear, Nose and Throat Society, Cleveland.

2:10 p.m. **Initiating a Hearing Testing Program in Industry** — D. W. Hillman, M.D., Medical Director of The Standard Oil Company in Cleveland.

2:20 p.m. **Hearing Conservation Program in Industry** — Patricia G. Britton, R.N., Twinsburg; President of the Northeast Ohio Association of Industrial Nurses.

2:30 p.m. **The Audiologist's Role in Hearing Conservation**—David A. Metz, Ph.D., Cleveland; Associate Professor of Audiology and Director of the Speech Pathology and Audiology Program at Cleveland State University.

2:40 p.m. **Noise Control for Hearing Conservation in Industry** — Thomas H. Rockwell, Acoustical Engineer at the Ordnance Research Laboratory (Penn State) and Acoustical Consultant, Environmental Technology Corporation, Cleveland.

2:50 p.m. (Presentation by) — Bert L. Scott, President, Environmental Technology Corporation, Cleveland.

3:00 p.m. **Workmen's Compensation Law Aspects of Occupational Hearing Problems** — Benjamin Sheerer, Attorney, Cleveland; Mr. Sheerer specializes in representing claimants in workmen's compensation.

Moderator: Thomas W. Wykoff, M.D., Cleveland
Panel Program Presentations followed by Question and Answer Period.

4:00-
4:30 p.m. Business Meeting, E.N.T. Society and Section

TUESDAY, MAY 14

OPHTHALMOLOGY

3:00 p.m.
Gold Room, Mezzanine Floor

Program sponsored by the Section on Ophthalmology and the Ohio Ophthalmological Society.

PROGRAM

Introduction: Froncie A. Gutman, M.D., Cleveland, Secretary, Section on Ophthalmology.
Presiding: Joel G. Wachtel, M.D., Columbus, Chairman, Section on Ophthalmology.

3:00 p.m. **Current Approaches to the Medical and Surgical Management of Herpetic Keratitis** — Roger H. S. Langston, M.D., Cornea Service, Massachusetts Eye and Ear Infirmary, Boston, Mass.

3:30 p.m. Discussion

3:40 p.m. **Ultrasonography of the Eye and Orbit** — William Cappaert, M.D., Instructor, Department of Ophthalmology, University Hospital, Cleveland.

4:20 p.m. **Ophthalmic Plastic Repair of Congenital Defects** — Allison J. Berlin, Jr., M.D., Department of Ophthalmology, Cleveland Clinic.

4:50 p.m. Discussion

WEDNESDAY, MAY 15

NEUROLOGICAL SURGERY

8:00 a.m. (All Day)

Program sponsored by the Section on Neurosurgery and the Ohio State Neurosurgical Society.

HONORED GUEST

Dr. Paul C. Bucy

Emeritus Professor and Chairman of Neurosurgery, Northwestern University School of Medicine (Chicago); Editor and Publisher of *Surgical Neurology.*

Morning Session: Cleveland Metropolitan General Hospital
Scott Auditorium

8:00 a.m. European Breakfast — First Floor Galley
(Top of Scott Auditorium)

Morning Symposium

THE PRESENT AND FUTURE OF NEUROSURGICAL PRACTICE

Dedication: To Dr. W. James Gardner, Emeritus Director of Neurosurgery, The Cleveland Clinic; Distinguished Surgeon, educator and innovator

Presiding: Dr. Robert J. White, Cleveland

8:30 a.m. Welcome: Dr. Walter J. Pories, Director of Surgery, and Chairman, The Medical Executive Committee, CM-GH: Professor of Surgery, Case Western Reserve University School of Medicine.

8:35 a.m. Introduction: Dr. R. J. White

8:40 a.m. **Politics, National and Medical: The Neurosurgeon's Role and Stake**—Dr. Frank Mayfield.

9:00 a.m. **The Future of Neurosurgical Practice in the Private Hospital** — Dr. J. Wolkin.

9:20 a.m. **The Neurosurgeon and Finances: The Now (3rd Party Carriers) and the Future (National Health Insurance)** — Dr. E. Bishop

9:40 a.m. Discussion

9:50 a.m. Intermission

10:00 a.m. **The Present and Future of Neurosurgical Training** — Dr. F. E. Nulsen.

10:20 a.m. **Neurosurgical Board Examination: Where Is It Going?** — Dr. D. Dohn

10:40 a.m. **The Neurosurgeon and Medical-Legal Shock** — Dr. W. Trowbridge

11:00 a.m. Overall Discussion

11:20 a.m. Intermission

11:30 a.m. **The Surgical Treatment of Gliomas** —Dr. Paul C. Bucy

12:20 p.m. Discussion
End of Morning Program

1:00 p.m. Luncheon: Jim's Steak House, 1800 Scranton Road.

AFTERNOON PROGRAM

Empire Room, Parlor Floor
2:00 P.M.

Presiding: James E. Barnes, M.D., Columbus, President, Ohio State Neurosurgical Society.

2:00 p.m. **Treatment of Internal Carotid Artery Aneurysm by Carotid Ligation**—Melvin Shafron, M.D. and Julius Wolin, M.D., Cleveland.

2:10 p.m. **The Use of the Sundt Clip in Rupturing Internal Carotid Aneurysms**—David Lehtinen, M.D., Wayne Beveridge, M.D., Yoshiro Takaoka, M.D., Ph.D., William M. Hegarty, M.D., and Robert J. White, M.D., Ph.D., Cleveland.

2:20 p.m. **Narrow Lumbar Spinal Canal Syndrome as an Etiologic Factor in the Production of Intermittent Neurogenic Claudication**—Frank Mayfield, M.D. and John Tew, Jr. M.D. and Jorge Davila, M.D., Cincinnati.

2:30 p.m. Discussion

2:40 p.m. Exhibits

Presiding: Bert H. McBride, M.D., Cincinnati, Vice-President, Ohio State Neurosurgical Society.

3:00 p.m. **Craniopharyngioma—Report of (12) Cases and Discussion of Approach to their Management**—Set Shahbabian, M.D., Frank H. Mayfield, M.D. and John M. Tew, Jr., Cincinnati.

3:10 p.m. **Transphenoidal Pituitary Microsurgery** — Gerald Brodkey, M.D., and Frank E. Nulsen, M.D., Cleveland.

3:20 p.m. **Craniolacunia — The Result of Fetal Hydrocephalus** — W. James Gardner, M.D. and Pete N. Poolos, Jr., M.D., Cleveland.

3:30 p.m. **The Blood-Cord Barrier in Spinal Cord Injury** — Michael Vise, M.D., David Yashon, M.D. and William Hunt, M.D., Columbus.

3:40 p.m. Discussion

3:50 p.m. Intermission

(Continued on Next Page)

NEUROSURGICAL PRACTICE *(Contd.)*

Presiding: William M. Hegarty, M.D., Cleveland

4:00 p.m. **Spinal Cord Injury** — Paul C. Bucy, M.D., Emeritus Professor and Chairman of Neurosurgery, Northwestern University School of Medicine; Editor, *Surgical Neurology.*

4:50 p.m. Discussion

5:00 p.m. Annual Ohio State Neurosurgical Society Business Meeting — James Barnes, M.D., Presiding.

7:00 p.m. Cocktails — The Park Plaza Hotel, Cleveland Clinic (prepaid)

8:00 p.m. Dinner — The Park Plaza Hotel (Cleveland Clinic) (prepaid)

WEDNESDAY, MAY 15

9:00 A.M.
Grand Ballroom Terrace, Parlor Floor

PROBLEMS AND QUESTIONS REGARDING EARLY EMERGENCY CARE AND HOSPITAL EMERGENCY DEPARTMENTS

Program organized by the Ohio Committee on Trauma, A.C.S. with the assistance of the OSMA Section on Plastic Surgery and Section on Emergency Medicine.

PROGRAM

Moderator: Robert C. Waltz, M.D., Cleveland, Chairman, Ohio Committee on Trauma, A.C.S.

9:00 a.m. **Early Care of Face and Soft Tissue Injuries**—John Des Prez, M.D., University Hospitals, Cleveland.

9:20 a.m. **The Need for Improved Emergency Medical Service** — Walter Pories, M.D., Professor of Surgery, Case Western Reserve University.

9:40 a.m. **Legal Aspects of Pre-Hospital Emergency Care**—William Dornette, M.D., Department of Anesthesia, Cleveland Clinic.

10:00 a.m. **Seven Pitfalls in E.D. Management**—Rauf Z. Unver, M.D., Head, Massillon City Hospital Emergency Department.

10:20 a.m. Coffee Break

10:50 a.m. **Should I, Could I—Become an E.R. Physician?**—H. Thomas Blum, M.D., Medical Director for the Emergency Unit, University of Cincinnati Medical Center.

11:00 a.m. **Some Unresolved Questions Regarding E.D. Physicians** — Oscar P. Hampton, Jr., M.D., St. Louis, Missouri; Assistant Director of the American College of Surgeons and Director of its Trauma Division; Associate Professor (Emeritus) of Clinical Orthopaedic Surgery, Washington University, St. Louis; Past President of the American Association for the Surgery of Trauma.

11:20 a.m. Panel Discussion
Moderator: Robert C. Waltz, M.D.
Panelists: Drs. Pories, Dornette, Unver, Blum and Hampton.

12:00 Noon Luncheon — Ohio Committee on Trauma

1:00 p.m. Executive Committee, Ohio Committee on Trauma

WEDNESDAY, MAY 15

10:30 a.m.

PLASTIC SURGERY

Mohawk Room, First Floor

Program presented by the Ohio State Society of Plastic and Reconstructive Surgeons; and Cleveland Society of Plastic Surgeons.

THE PROGRAM

Selected Topics in Plastic Surgery—
"How I Do It"

Presiding: Stanley Jaffe, M.D., Cleveland, Program Chairman

10:30 a.m. **Reduction Mammoplasty** — A. Scott Earle, M.D., Metropolitan General Hospital, Cleveland.

10:50 a.m. **Repair of Flexor Tendons in "No Man's Land"** — Robert J. Duran, M.D., Columbus.

11:10 a.m. **Maxillary Osteotomy**—John D. Des Prez, M.D., Cleveland.

(Continued on Page 263)

WHEN YOUR DIGITALIZED PATIENT NEEDS A DIURETIC, SHE NEEDS DYAZIDE®



- relieves edema*
- conserves potassium
- reduces the risk of digitalis intoxication due to potassium depletion. Potassium depletion sensitizes the myocardium to the toxic effects of digitalis, and reduces its inotropic effect.

Trademark

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

MEETS THE HEARTFELT NEED OF THE DIGITALIZED PATIENT

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles and Single Unit Packages of 100 capsules.

SK&F CO.
Carolina, P.R. 00630
Subsidiary of SmithKline Corp.

The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatology

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association



Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005

P·M·A



Placidyl®
(ETHCHLORVYNOL)
Brief Summary

Indications—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

Contraindications—Drug hypersensitivity and porphyria.

Warnings—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. Administer with caution to patients with suicidal tendencies and do not prescribe large quantities of the drug. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

Precautions—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitryptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 302430R

Give us her nights.

Prescribe Placidyl. Chances are, we'll give her a good night's sleep.

Insomnia is often associated with emotional disturbance. Emotional problems might be the cause . . . or the effect. In time that can be determined. But tonight, one fact is painfully clear: she needs sleep.

When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

If time is the criterion to inspire your confidence... you can rest assured with Placidyl.

Prescribed by physicians for over 17 years.

Placidyl®
(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)

PLASTIC SURGERY *(Contd.)*

11:30 a.m. **The Face Lift** — James B. Kahl, M.D., Cincinnati

11:50 a.m. **Two State Repair of Cleft Palate** — George J. Baibak, M.D., Toledo.

12:10 p.m. **Odds and Ends** — Philip A. Weisman, M.D., Dayton.

12:45-
2:00 p.m. Luncheon (Chieftain Room, First Floor)
Business Meeting
Ohio State Society
Cleveland Society

WEDNESDAY, MAY 15
PSYCHIATRY

8:00 a.m. (All Day)
Lewis Room, Lobby Floor

Program sponsored by the Ohio Psychiatric Association and the Section on Psychiatry and Neurology.

PROGRAM

RECENT ADVANCES IN PSYCHOLOGICAL APPROACH

8:00 a.m. Registration

8:30 a.m. Welcome: Bartholomew Clemente, M.D., Chairman, Section on Psychiatry and Neurology, Akron

8:45 a.m. Introductory Remarks:
Gusztav A. Batizy, M.D., Clinical Associate, Medical College of Ohio at Toledo; Program Chairman, Section on Psychiatry and Neurology, Akron.

9:00 a.m. **Psychoanalysis** — Justin Krent, M.D., Chairman, Educational Committee, Cleveland Psychoanalytic Institute, Cleveland.

10:00 a.m. **Gestalt Therapy** — Cynthia Harris, M.D., President, Gestalt Institute of Cleveland.

11:00 a.m. **Transactional Analysis** — Arnold Kambly, M.D., Medical Director of the University Center Hospital, Ann Arbor, Michigan.

12:00 Noon Luncheon — Ohio Psychiatric Association and Section on Psychiatry and Neurology (Parlor 34, Parlor Floor)
Business Meeting
Presidential Address:

L. Douglas Lenkoski, M.D., Professor and Chairman in Psychiatry, Case Western Reserve University; President, Ohio Psychiatric Association, Cleveland.

1:00 p.m. **Ewing H. Crawfis Memorial Lecture**
Speaker: Douglas Bond, M.D., Professor and Former Chairman in Psychiatry, Case Western Reserve University, Cleveland.

Topic: **Future of Psychoanalysis**

2:00 p.m. **Metapsychiatry: The Interface Between Psychiatry and Mysticism** — Stanley R. Dean, M.D., Miami, Florida; Clinical Professor of Psychiatry, University of Florida College of Medicine; Clinical Professor of Psychiatry, University of Miami School of Medicine.

3:00 p.m. **Tony Agpaoa's Psychic (Bare-hand) Surgery with Explanatory Comments** — Stanley R. Dean., Miami, Florida.

4:00 p.m. **Behavior Therapy** — Leslie Solyom, M.D., Associate Professor, McGill University, Montreal, Quebec, Canada.

This program is part of the Continuous Education Program of the Ohio Psychiatric Association. This course is also accredited as a First Category, Continuous Medical Education Activity by the American Medical Association (7 credit hours), as well as acceptable for (7) elective hours by the American Academy of Family Physicians.

Art Show Planned

FOR 1974 OSMA ANNUAL MEETING

Space will be provided at the 1974 Annual Meeting of the Ohio State Medical Association, Monday, May 12th through Wednesday, May 15th for a Physicians' Art Show. The Art Committee of the Academy of Medicine of Cleveland will merge their efforts with those of the Committee on Scientific Work of the Ohio State Medical Association, for the creation of a magnificent Art Show at the annual meeting.

Members of the OSMA, their wives (or husbands), who are interested in exhibiting pieces of art work (they personally have created) or who require information concerning the exhibit, should fill out the application included below *without delay.*

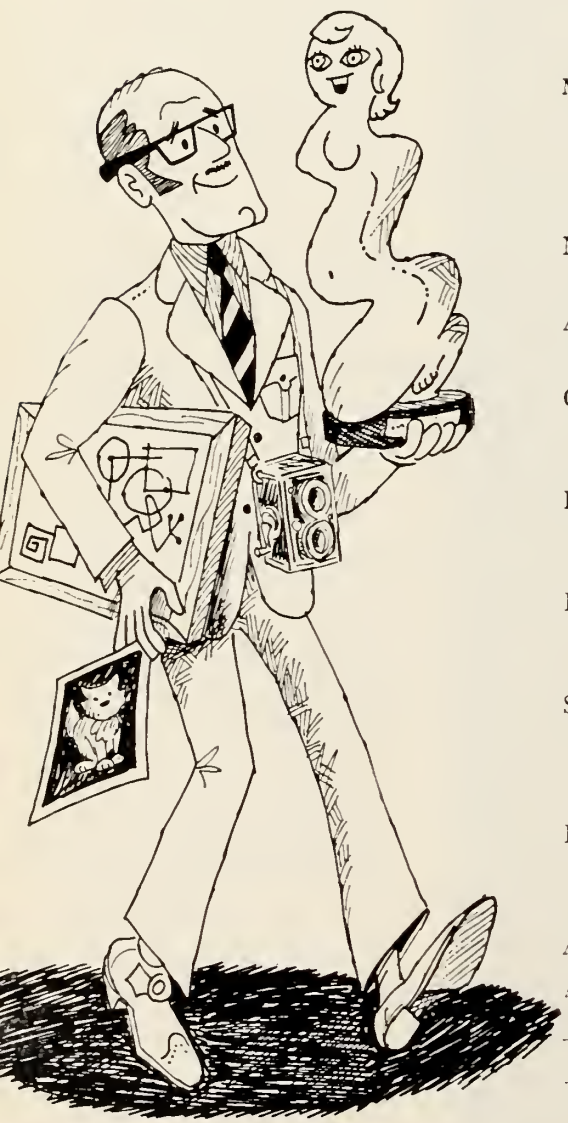
It will be the responsibility of each exhibitor to see that his work gets to the exhibit area, on the balcony of the Exhibit Hall, in the Sheraton-Cleveland Hotel, NO SHIPMENTS WILL BE ACCEPTED. Time to receive such deliveries: Monday, May 13th from 8:00 a.m. to 4:00 p.m. (the earlier the better). No exhibits can be accepted after 4:00 p.m. on Monday, 13th (except by very special arrangements).

Each exhibitor will be responsible for transportation costs, insurance and other expenses involved in entering his or her exhibit. Guards will be provided for protection.

Exhibitors will be limited to two art pieces per category. Categories will be (1) Paintings (watercolor); (2) Paintings (oil) and (acrylics); (3) Sculpture; (4) Photo-Arts; and (5) Crafts.

An independent Art Award Committee will judge the exhibit competitively—ribbons will be awarded.

We solicit your exhibits and hope you will assist us to make the 1974 Art Show an outstanding success.



Application for Space in 1974 OSMA Art Show Exhibit

Mail to: **Victor C. Laughlin, M.D., Chairman**
1974 OSMA Art Show Committee
Academy of Medicine of Cleveland
10525 Carnegie Avenue
Cleveland, Ohio 44106

Name_____

Address_____

City_____ Zip Code_____

		Title	Dimensions	Value
Paintings (watercolor)	1.			
	2.			
Paintings (oil & acrylics)	1.			
	2.			
Sculpture (pedestal— or wall type—	1.			
	2.			
Photo-Arts (mounted, ready to hang)	1.			
	2.			

Additional information desired or which you believe will be helpful to Art Show Committee. _____

(*Please include a fair market value for insurance)

You Are Invited To Attend...

THE EYE-FILLING

ART SHOW

Under the Chairmanship

of

Victor C. Laughlin, M.D.

President-Elect
American Physicians Art Association

DURING THE

1974 OSMA ANNUAL MEETING

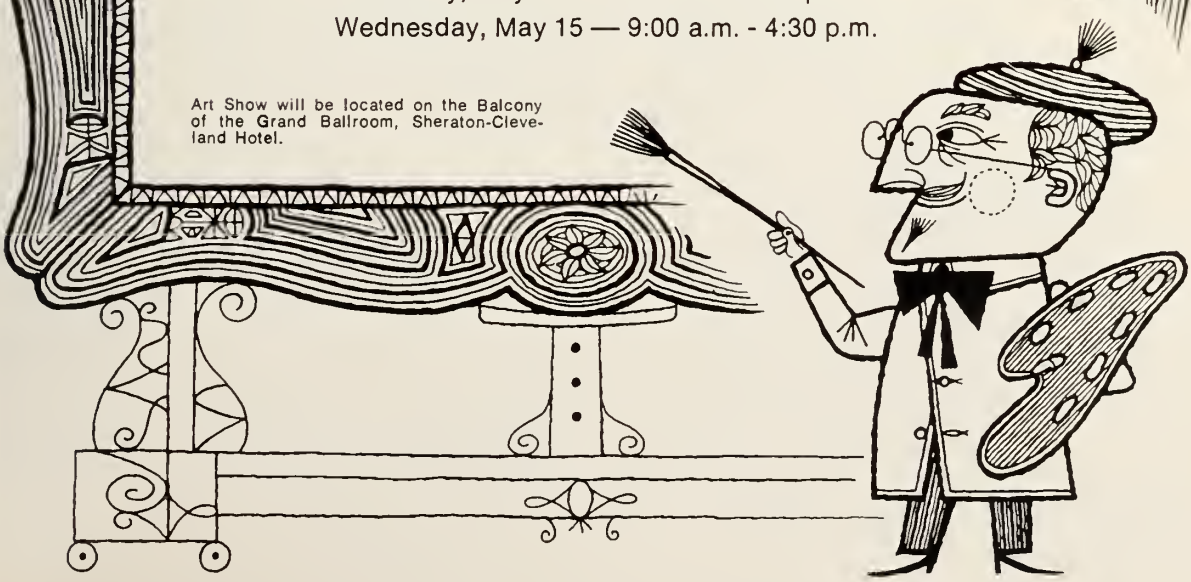
MAY 12 - 15

SHERATON-CLEVELAND HOTEL

Viewing Hours:

Monday, May 13 — 5:30 p.m. - 8:00 p.m.
Tuesday, May 14 — 9:00 a.m. - 4:30 p.m.
Wednesday, May 15 — 9:00 a.m. - 4:30 p.m.

Art Show will be located on the Balcony of the Grand Ballroom, Sheraton-Cleveland Hotel.

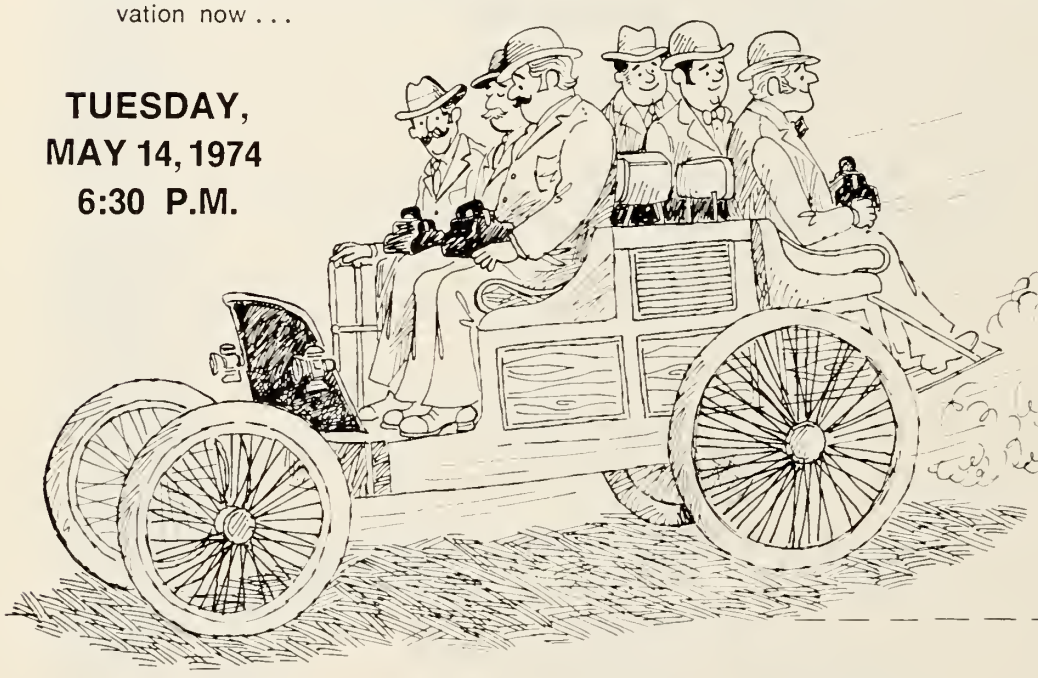


OSMA'S Olde but Goode Night

The lovely, unique Frederick C. Crawford Auto-Aviation Museum located in University Circle in Cleveland will be the location of the 1974 OSMA Social Function held in connection with the OSMA Annual Meeting. It will be an evening of do you remember when . . . as you wander through a collection restored antique cars and aircraft. In addition to this bit of nostalgia . . . a composite of a MAIN STREET to be found in Ohio between 1890 and 1900. Each shop is carefully detailed being recreated and named for Cleveland businesses. Most of contents and equipment of these shops have been garnered from the original stores whose names each retains. This interesting historic street is to be found on the lower level of the museum.

What else will happen at OSMA's Olde but Goode Night . . . cocktails . . . a buffet dinner and dancing to the Joe Hruby Orchestra. Bus service to and from the Sheraton-Cleveland Hotel will be provided by OSMA. Make your reservation now . . .

TUESDAY,
MAY 14, 1974
6:30 P.M.



MAKE YOUR RESERVATION TODAY!

Annual Meeting Pre-Registration and Ticket Form

SOCIAL FUNCTION TICKET RESERVATIONS

Note: (No Tickets reserved without money)

Make checks payable to: **Ohio State Medical Association**

Mail this form to: **Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215**

Tuesday, May 14, 11:30 A.M.
"OMPAC Luncheon"
Sheraton-Cleveland Hotel
$7.50 per person

Number_____

Tuesday, May 14, 6:30 P.M.
"OSMA's OLDE But GOODE NIGHT"
Frederick C. Crawford Auto-Aviation Museum
$12.50 per person
(Special Price to all Exhibitors of $10.00 per person)

Number_____

Name_____
(Please Print)

Address_____
(Number and Street) (City) (State)

I am:

- ☐ OSMA Member
- ☐ Non-Member Physician
- ☐ Medical Student
- ☐ Guest

Other_____
(Fill in)

Do You Belong to OMPAC? Yes ☐ No ☐

Please prepare guest badge for my spouse.

_____
(Please print name)

HOUSE OF DELEGATES

BUSINESS AGENDA

SUNDAY, MAY 12, 1974
3:00-7:00 P.M.
Registration for OSMA House of Delegates
Gold Room Assembly
Mezzanine Floor
SHERATON-CLEVELAND HOTEL
4:00 P.M.
Councilor District Caucus Meetings
Sheraton-Cleveland Hotel

District	Councilor	Room Number
First	Stephen P. Hogg	8A1
Second	James G. Tye	6A1
Third	John C. Smithson	5A1
Fourth	George N. Bates	3A1
Fifth	John J. Gaughan	9B1
Sixth	Maurice F. Lieber	7C1
Seventh	Robert E. Rinderknecht	7A1
Eighth	Richard E. Hartle	4C1
Ninth	Thomas W. Morgan	3C1
Tenth	James C. McLarnan	PA1
Eleventh	Robert G. Thomas	4A1

First Session, House of Delegates
SUNDAY, MAY 12, 1974
7:00 P.M.

Call to order by the President—Oscar W. Clarke, M.D., Gallipolis

Invocation—Rev. Duane Smith, Associate Minister, Grove City Methodist Church, Grove City

Welcome by James R. O'Malley, M.D., Cleveland, President, Academy of Medicine of Cleveland and Cuyahoga County

Address: Max H. Parrott, M.D., Portland, Oregon, AMA Board of Trustees.

Report of the Committee on Credentials.

Consideration of the Minutes of the last Annual Meeting (July 1973 issue of The Journal)

Introduction of honored guests.

Report by the President of the Woman's Auxiliary —Mrs. Karl Ulicny, Salem.

Presentation of AMA-ERF Checks to representative of Ohio Medical Schools—Philip B. Hardymon, M.D., Columbus, Chairman, Ohio Committee of AMA-ERF. University of Cincinnati College of Medicine; Case Western Reserve University School of Medicine; Ohio State University College of Medicine and the Medical College of Ohio at Toledo.

Presentation of plaques to Past Councilors and retiring AMA Delegates and Alternates; Chairmen and members of Standing Committees and Chairmen of Special Committees.

Presentation of Life Memberships

Presentation of Distinguished Service Citation

Announcement of appointments to the Reference Committees by the President: Credentials; President's Address; Resolutions; and Tellers and Judges of Election.

Election of Committee on Nominations:
(Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the second and final session, Wednesday, May 15, 3:30 p.m., its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the First District shall serve as chairman). The report of the Nominating Committee with respect to all offices except President-Elect shall be posted at registration desk, earliest time practicable and at least three hours before the final session of the House of Delegates.

President's Address:
Oscar W. Clarke, M.D., Gallipolis

Introduction of Presidents of other State Societies.

Introduction of Resolutions:
(Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Wednesday afternoon session before any action can be taken. All resolutions not submitted in advance of the 60-day deadline must be typewritten and submitted in triplicate.)

Miscellaneous Business.

(Continued on Next Page)

MONDAY, MAY 13, 1974

REFERENCE COMMITTEES

(All Reference Committee Meetings held in rooms on Parlor Floor, Sheraton-Cleveland Hotel)
8:30 A.M.

Resolutions Committee No. 1	Erie Room
Resolutions Committee No. 2	Terminal Room
Resolutions Committee No. 3	P-34
President's Address	P-28
Committee on Nominations	P-26

(Note: If necessary the Reference Committees will meet in the same rooms, Monday afternoon, May 13, 1:30 P.M.)

RESOLUTIONS COMMITTEE NO. 1

District 11
Luther W. High, Chairman (Holmes)
District 1
Milton Gwinner (Hamilton)
District 2
W. J. Lewis (Montgomery)
District 3
Walter A. Daniel (Seneca)
District 4
B. Leslie Huffman (Lucas)
District 5
John H. Sanders (Cuyahoga)
District 6
W. Paul Kilway, Jr. (Summit)
District 7
Philip T. Doughten (Tuscarawas)
District 8
Gregory B. Krivchenia (Washington)
District 9
A. Burton Payne (Lawrence)
District 10
Homer A. Anderson (Franklin)

RESOLUTIONS COMMITTEE NO. 2

District 5
Theodore J. Castele, Chairman (Cuyahoga)
District 1
James M. Smith (Butler)
District 2
Ernest H. Winterhoff (Clark)
District 3
David A. Barr (Allen)
District 4
Harry C. Mack (Lucas)
District 6
William Dorner, Jr. (Summit)
District 7
Sanford Press (Jefferson)
District 8
Walter B. Devine (Muskingum)
District 9
Thomas P. Price, Jr. (Gallia)
District 10
John N. Meagher (Franklin)
District 11
A. Burney Huff (Wayne)

RESOLUTIONS COMMITTEE NO. 3

District 4
Roland A. Gandy, Jr., Chairman (Lucas)
District 1
Carl A. Minning (Clermont)
District 2
Chester J. Brian (Preble)
District 3
Paul E. Lyon (Marion)
District 5
Alton W. Behm (Geauga)
District 6
E. Joel Davis (Stark)
District 7
A. John Antalis (Belmont)
District 8
James A. L. Toland (Guernsey)
District 9
Chester H. Allen (Scioto)
District 10
Henry T. Lapp (Knox)
District 11
Jon H. Cooperrider (Ashland)

TELLERS & JUDGES

District 5
Lawrence J. McCormack, Chmn. (Cuyahoga)
District 1
John E. Albers (Hamilton)
District 4
Richard J. Wiseley (Lucas)
District 6
William E. Sovik (Mahoning)
District 7
H. Judson Reamy (Tuscarawas)
District 8
Robert A. Ringer (Guernsey)

PRESIDENT'S ADDRESS

District 5
P. John Robechek, Chairman (Cuyahoga)
District 10
Richard L. Fulton (Franklin)
District 9
Thomas W. Morgan (Gallia)

CREDENTIALS

District 10
Joseph A. Bonta, M.D., Chairman (Franklin)
District 4
Peter A. Overstreet, M.D. (Lucas)
District 1
Marvin McClellan, M.D. (Hamilton)
District 5
Vincent T. La Maida, M.D. (Cuyahoga)
District 11
S. Baird Pfahl, Jr., M.D. (Erie)

HOUSE OF DELEGATES

FINAL SESSION

WEDNESDAY, MAY 15, 1974

2:30-3:30 P.M.

Registration for OSMA House of Delegates
Lobby East, Mezzanine Floor

3:30 P.M.

OSMA House of Delegates Final Business Session
Gold Room, Mezzanine Floor

6:00 P.M.

Buffet Dinner for Delegates, Alternates, OSMA Council and Official Guests
Whitehall Room, Mezzanine Floor

BUSINESS AGENDA

Final Session, House of Delegates
3:30 P.M.

Introduction of Guests

Report of Committee on Credentials

Election of President-Elect

Report of Committee on Nominations and Election of other officers.

(a) Nominations for The Council
(Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-numbered years).

First District—(Incumbent, Stephen P. Hogg, M.D., Cincinnati)

Third District—(Incumbent, John C. Smithson, M.D., Findlay)

Fifth District—(Incumbent, John J. Gaughan, M.D., Cleveland) Note: Dr. Gaughan was appointed by The Council to succeed David Fishman, M.D., Cleveland, Deceased May, 1973. The OSMA Constitution and Bylaws provide that a Councilor appointed in this manner will serve until the next election.)

Seventh District—(Incumbent, Robert E. Rinderknecht, M.D., Dover)

Ninth District — (Incumbent, Thomas W. Morgan, M.D., Gallipolis)

Eleventh District — (Incumbent, Robert G. Thomas, M.D., Elyria)

(b) Election of Delegates and Alternates to the American Medical Association—4 Delegates and 4 Alternates to be elected each for a two-year term starting January 1, 1975 in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1974, their terms expiring December 31, 1974.

Delegates: (Listed alphabetically)
Richard L. Meiling, M.D., Columbus
Lawrence C. Meredith, M.D., Oberlin
Robert N. Smith, M.D., Toledo
Robert E. Tschantz, M.D., Canton

Alternates: (Listed alphabetically)
Dwight L. Becker, M.D., Lima
B. Leslie Huffman, Jr., M.D., Toledo
H. William Porterfield, M.D., Columbus
(one vacancy) created due to the death of David Fishman, M.D., Cleveland.

All nominees for the office of AMA Delegates and AMA Alternates shall run at large.

Election of Delegates and Alternates of the AMA shall be governed by Section 6, Chapter 5 of the OSMA Constitution and Bylaws as revised by the House of Delegates in May, 1971.

Reports of Reference Committees.

President's Address

Resolutions Committee No. 1

Resolutions Committee No. 2

Resolutions Committee No. 3

Miscellaneous Business

Installation of Officers for 1974-75.

Announcement of Standing Committee Appointments by the newly installed President and action thereon by House of Delegates.

Unfinished business.

Adjournment.

MEMBERS OF THE 1974 HOUSE OF DELEGATES

Listed in the following columns are Delegates and Alternate Delegates to the Ohio State Medical Association House of Delegates, as reported from each county to represent their respective County Medical Societies at the 1974 OSMA Annual Meeting, May 12-15. All business sessions of the House of Delegates will be held at the Sheraton-Cleveland Hotel, 24 Public Square, Cleveland, Ohio.

COUNTIES		
Delegates		Alternates
FIRST DISTRICT		
ADAMS		
Francis L. Stevens		William J. Lundy
BROWN		
John R. Donohoo		Kevin C. McGann
BUTLER		
Jerry D. Hammond		Joseph H. Brandabur
James M. Smith		Frank C. Palmer
James F. Stewart		James I. Scott, Jr.
CLERMONT		
Carl A. Minning		Donald R. Morath
CLINTON		
Foster K. Boyd		
HAMILTON		
Eugene J. Burns		John E. Albers
Ambrose H. Clement		Donald E. Brinkman
Edmund C. Casey		Frederick Brockmeier
Joseph G. Crotty		George D.J. Griffin
William D. Culbertson, Jr.		James L. Leonard
Frank D. Feuss, Jr.		Frederick T. Martin
Milton W. Gwinner		H. Glenn Overley
Robert S. Heidt		Joseph O. Porter
Harry K. Hines		Eli Rubenstein
Stephen P. Hogg		Elmer Schlueter
Marvin McClellan		Carl J. Schmidt
Glenn W. Pfister		William J. Schrimpf
Clyde S. Roof		Calvin F. Warner
Harold Schiro		
Albert E. Thielen		
Andrew J. Weiss		
HIGHLAND		
WARREN		
Thomas E. Fox		Gary P. Hayes
SECOND DISTRICT		
CHAMPAIGN		
Isador Miller		John H. Flora
CLARK		
Henry A. Diederichs		Lawrence J. Mervis
Ernest H. Winterhoff		James W. Keller
DARKE		
		Jose R. Solis
GREENE		
Roger C. Henderson		Paul C. Vernier
MIAMI		
A. Robert Davies		Albert C. Howell

COUNTIES	
Delegates	Alternates
SECOND DISTRICT (Contd.)	
MONTGOMERY	
R. Alan Baker	Robert K. Finley, Jr.
A. J. Gabriele	Samuel A. Laneve
W. J. Lewis	Konrad A. Kircher
Benjamin Schuster	Frederic C. Schnebly
John H. Taylor	John R. Whitaker, Jr.
PREBLE	
Chester J. Brian	E. P. Trittschuh
SHELBY	
George J. Schroer	
THIRD DISTRICT	
ALLEN	
David A. Barr	Robert L. Holladay
J. M. Oppenheim	Alexander C. Reed
AUGLAIZE	
Elizabeth Y. Kuffner	
CRAWFORD	
Johnson H. Chow	V. Allen Auchard
HANCOCK	
John C. Smithson	Chester L. Samuelson
HARDIN	
Robert B. Elliott	John H. Hughes
LOGAN	
James H. Steiner	David R. Miller
MARION	
Paul E. Lyon	
MERCER	
James J. Otis	Donald R. Fox
SENECA	
Walter A. Daniel	John C. Bauer
VAN WERT	
A. C. Diller	Harold C. Smith
WYANDOT	
Konstantine K. Solacoff	
FOURTH DISTRICT	
DEFIANCE	
Paul E. Brose	Francis M. Lenhart
FULTON	
Benjamin H. Reed, Jr.	William J. Neal
HENRY	
Reynaldo C. Soriano	Thomas F. Moriarty

COUNTIES	Delegates	Alternates
FOURTH DISTRICT (Contd.)		
LUCAS		
	C. Douglass Ford	M. Brodie James
	Roland A. Gandy, Jr.	Richard J. Wiseley
	B. Leslie Huffman	Robert Page
	Harry C. Mack	Harry L. Snyder
	Peter A. Overstreet	Henry R. Silverman
	Thomas J. O'Grady	Robert L. Hauman
OTTAWA		
	John F. Bodie	Patrick Hughes
PAULDING		
	Doyt E. Farling	K. A. Pritchard
PUTNAM		
SANDUSKY		
	Willis L. Damschroder	
WILLIAMS		
	John E. Moats	Robert Dilworth
WOOD		
	William H. Roberts	Clarence B. Nyce
FIFTH DISTRICT		
ASHTABULA		
	Samuel L. Altier	James G. Macaulay
CUYAHOGA		
	Matthew R. Biscotti	Felino V. Barnes
	William F. Boukalik	Robert R. Blondis
	John H. Budd	Donald F. Brittenum
	Theodore J. Castele	Roland D. Carlson
	Henry A. Crawford	John E. Coletta
	Nicholas G. DePiero	C. A. Colombi
	Clarence J. Huggins	Caldwell B. Esselstyn, Jr.
	Roscoe J. Kennedy	Marvin W. Evans
	Edward F. Kieger, II	James E. Fleming
	John A. Kmieck	Jac S. Geller
	Vincent T. LaMaida	Manuel E. Gordillo
	George P. Leicht	James C. Jones
	Leonard L. Lovshin	Edward G. Kilroy
	Hermann Menges, Jr.	Steven Kovacs
	James R. O'Malley	Fred V. Light
	George W. Petznick	James Magisano
	P. John Robechek	Lawrence J. McCormack
	John H. Sanders	Harlan R. Peterjohn
	A. B. Schneider	John G. Poulos
	Howard S. Siegel	Thomas H. Redding
	Frederick T. Suppes	Robert H. Redus, Jr.
	William V. Trowbridge	Paul J. Sindelar
	H. S. Van Ordstrand	Warner W. Tuckerman
		Robert W. Wido
GEAUGA		
	Alton W. Behm	Richard Sabransky
LAKE		
	Edward D. Hudgens	John J. Cahill
	Carl G. Madsen, Jr.	Harry A. Killian
SIXTH DISTRICT		
COLUMBIANA		
	William S. Banfield	Leonard S. Pritchard
MAHONING		
	J. James Anderson	William Moskalik
	John C. Melnick	William E. Sovik
	Charles E. Pichette	J. W. Tandatnick
	Jack Schreiber	C. Conner White, Jr.
PORTAGE		
	John F. Fulton	F. Michael Sheehan
STARK		
	Edward E. Grable	John D. Botti
	Frank O. Goodnough	Daniel A. Kibler
	E. Joel Davis	Walter J. Telesz
	William A. White, Jr.	Joseph P. Yut

COUNTIES	Delegates	Alternates
SIXTH DISTRICT (Contd.)		
SUMMIT		
	Rocco M. Antenucci	A. Dobkin
	Emmett P. Monroe	Charles A. East
	Robert R. Clark	James G. Roberts
	William Dorner, Jr.	Charles V. Bowen, Jr.
	John A. Karnoupakis	Roy E. Bugay
	W. Paul Kilway, Jr.	John D. Morley
	Marshall R. Werner	Joseph L. Kloss
TRUMBULL		
	Joseph L. Logan	Thaddeus D. McGuire
	Robert J. Paul	George Mokris
SEVENTH DISTRICT		
BELMONT		
	A. John Antalis	Theron R. Rolston
CARROLL		
	Carl A. Lincke	Thomas J. Atchison
COSHOCTON		
	Norman L. Wright	Donald E. Potts
HARRISON		
	Elias Freeman	Janis Trupovnieks
JEFFERSON		
	Sanford Press	Francis A. Sunseri
MONROE		
TUSCARAWAS		
	Philip T. Doughten	H. Judson Reamy
EIGHTH DISTRICT		
ATHENS		
	John F. Kroner, Jr.	James R. Gaskell
FAIRFIELD		
	Donald B. Nichols	James A. Merk
GUERNSEY		
	James A. L. Toland	Robert A. Ringer
LICKING		
	John P. Anderson, Jr.	William H. Overholser
MORGAN		
	Austin A. Coulson	Henry Bachman
MUSKINGUM		
	W. B. Devine	Carl E. Spragg
NOBLE		
	Edward G. Ditch	Frederick M. Cox
PERRY		
	Ralph Herendeen	George Tedrow
WASHINGTON		
	Gregory B. Krivchenia	Mary L. Whitacre
NINTH DISTRICT		
GALLIA		
	Thomas P. Price, Jr.	John F. Groth
HOCKING		
	L. W. Starr	Jan S. Matthews
JACKSON		
	Garrett B. Ackerman	Alvis R. Hambrick

COUNTIES	Delegates	Alternates
NINTH DISTRICT (Contd.)		
LAWRENCE	A. Burton Payne	Harry Nenni
MEIGS	Roger P. Daniels	
PIKE	Robert T. Leever	M. Marquez
SCIOTO	Chester H. Allen	Carter L.Pitcher
VINTON		
TENTH DISTRICT		
DELAWARE	Robert S. Caulkins, Jr.	Adelbert R. Callander
FAYETTE	Byers W. Shaw	Ralph Gebhart
FRANKLIN	Homer A. Anderson	Walter M. Haynes
	Michael A. Anthony	Thomas M. Hughes
	Robert C. Atkinson	Ben E. Jacoby
	James E. Barnes	F. M. Kapetansky
	Joseph A. Bonta	Charles W. Pavey
	Keith DeVoe, Jr.	H. William Porterfield
	Richard L. Fulton	J. Hutchison Williams
	John N. Meagher	Philip H. Taylor
	Jack E. Tetirick	Donald W. Traphagen
KNOX	Henry T. Lapp	Charles E. Cassaday
MADISON	Sol Maggied	C. Terrill Hay
MORROW	Joseph P. Ingmire	David James Hickson
PICKAWAY	Robert G. Smith	Ray Carroll
ROSS	Joseph McKell	Richard L. Counts
UNION	Paul R. Zaugg	Walter R. Burt
ELEVENTH DISTRICT		
ASHLAND	Jon H. Cooperrider	Charles H. Warne
ERIE	S. Baird Pfahl	Emil J. Meckstroth
HOLMES	Luther W. High	Maurice E. Mullet
HURON	Nino M. Camardese	Earl R. McLoney
LORAIN	Charles G. Adams	John N. Bartone
	Delbert L. Fischer	Henry E. Kleinhenz
	Harold E. McDonald	Andrew M. Mattey

COUNTIES	Delegates	Alternates
ELEVENTH DISTRICT (Contd.)		
MEDINA	Richard W. Avery	Rolland L. Mansell
RICHLAND	Harold F. Mills	Hall S. Wiedemer
	Charles B. Phillips	James W. Wiggin
WAYNE	A. Burney Huff	John M. Robinson

OFFICERS

President ..... Oscar W. Clarke
President-Elect ..... James L. Henry
Past President ..... William R. Schultz
Secretary-Treasurer ..... William M. Wells

COUNCILORS

First District ..... Stephen P. Hogg
Second District ..... James G. Tye
Third District ..... John C. Smithson
Fourth District ..... George N. Bates
Fifth District ..... John J. Gaughan
Sixth District ..... Maurice F. Lieber
Seventh District ..... Robert E. Rinderknecht
Eighth District ..... Richard E. Hartle
Ninth District ..... Thomas W. Morgan
Tenth District ..... James C. McLarnan
Eleventh District ..... Robert G. Thomas

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Lincoln, Nebraska 68501



*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

73 The Upjohn Company J-3437-6

Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent
4 gm vials containing 10 ml when reconstituted with diluent
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml) Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creotinine clearance; elevation of alkoline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

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Medical Director

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nicotinic acid therapy

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LIPO-NICIN/100 mg. Eech blue tablet contains: Nicotinic Acid .....100 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiemine HCL (B-1) .... 25 mg. Riboflevin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 5 teblets deily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/250 mg.** Each yellow tablet contains: Nicotinic Acid .....250 mg. Niacinemide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflevin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 teblets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/300 mg.** Each timed-release capsule contains: Nicotinic Acid .....300 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000

Indications: For use as a vesodiletor in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitent administration of the listed vitemins. The werm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects thet often produce psychological benefits to the patient. **Side Effects:** Transient flushing end feeling of warmth seldom require discontinuetion of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant petients and patients with glaucoma, severe diebetes, impaired liver function, peptic ulcers, and arteriel bleeding.

WRITE FOR LITERATURE AND SAMPLES
BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th St., Los Angeles, CA 90057
REFER TO PDR

Resolutions Submitted for Consideration At the 1974 Annual Meeting

IN THE FOLLOWING COLUMNS are texts of several resolutions and titles of others scheduled to be presented for consideration by the House of Delegates at the 1974 Annual Meeting of the Ohio State Medical Association, May 12-15, in Cleveland. These resolutions were received in the Columbus Office on or before March 13, thereby meeting the 60-day deadline.

No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submissions were justified. Please refer to Chapter 4, Section 8 of the OSMA Bylaws entitled, Resolutions for complete clarification.

Copies of all resolutions presented to the Columbus Office are being sent to the individual delegates and alternate delegates so that they may discuss them with their county medical societies.

RESOLUTION NO. 1-74
New Councilor District
(By the Trumbull County Medical Society)

WHEREAS, We are suburban, rural and contiguous counties whose social, economic and educational problems are similar, and at the same time dissimilar from large metropolitan areas, and

WHEREAS, A single Councilor representing both types of practice would find it difficult to represent the divergent interests of the patients and the physicians involved, and

WHEREAS, The House of Delegates is empowered to approve the creation of Councilor Districts as part of its usual business at the Annual Meeting (Chapter 4, Section 6, page 5, of the Ohio State Medical Association Bylaws), and

WHEREAS, Precedent has recently been set when the involved areas were split up for administrative purposes, and

WHEREAS, There is a common desire on the part of the county societies involved to join together for their mutual benefit, THEREFORE BE IT

RESOLVED, That a new Councilor District be established which would include Ashtabula, Lake and Trumbull Counties.

RESOLUTION NO. 2-74
New Councilor District
(By the Ashtabula County Medical Society)

WHEREAS, We are suburban, rural and contiguous counties whose social, economic and educational problems are similar, and at the same time dissimilar from large metropolitan areas, and

WHEREAS, A single Councilor representing both types of practice would find it difficult to represent the divergent interests of the patients and the physicians involved, and

WHEREAS, The House of Delegates is empowered to approve the creation of Councilor Districts as part of its usual business at the Annual Meeting (Chapter 4, Section 6, Page 5, of the Ohio State Medical Association Bylaws), and

WHEREAS, Precedent has recently been set when the involved areas were split up for administrative purposes, and

WHEREAS, There is common desire on the part of the county societies involved to join together for their mutual benefit, THEREFORE BE IT

RESOLVED, That a new Councilor District be established which would include Ashtabula, Lake and Trumbull counties.

RESOLUTION NO. 3-74
Circumvention of Democratic Process
(By the Ross County Medical Society)

WHEREAS, Ross County's resolution regarding the medical ethics of signing the provider agreement with the ODPW was submitted to the 1973 Ohio State Medical Association's House of Delegates, and

WHEREAS, The Council of OSMA chose to not have the House of Delegates of OSMA hear testimony or vote on this resolution, but referred it to the Council of OSMA for action, and

WHEREAS, At the time of submission of this resolution the Ross County Medical Society has had no communication from the Council of OSMA regarding action on the 1973 resolution, nor has there been published in the Journal of OSMA under Proceedings of the Council, any information on action on this resolution, and

WHEREAS, The Ross County Medical Society has had no opportunity to present its reasons for submitting this resolution, and

WHEREAS, This failure to provide a fair hearing of the 1973 resolution is a blatant circumvention of the democratic process, the absence of which is destroying our association, THEREFORE BE IT

RESOLVED, In the future all resolutions regardless of content must be discussed in reference committees and voted on by the House of Delegates, and BE IT FURTHER

RESOLVED, The members of the OSMA Council be directed that their purpose is to serve the physicians of Ohio and are censored for the aforementioned failure to act, and BE IT FURTHER

RESOLVED, The 1973 resolution be re-entered into the proceedings of the 1974 House of Delegates and be voted on at this time, and BE IT FURTHER

RESOLVED, The Constitution and Bylaws of the Ohio State Medical Association be appropriately amended to provide for the implementation of this resolution.

(Continued on Next Page)

RESOLUTION NO. 4-74

Appointment of Members to Resolutions Committees

(By the Mahoning County Medical Society)

WHEREAS, The only voice that the individual physician member in Ohio has at the annual meeting of the OSMA House of Delegates is through the delegates whom he has elected from his own county to represent him, and

WHEREAS, Each delegate is both informed by, and responsive to, the individual members of his own county medical society who elected him to represent them, and

WHEREAS, Resolutions presented before the House of Delegates are the written testimony of the thoughts and actions of the individual members working together in their own county society meetings, and

WHEREAS, The fate of these resolutions is greatly influenced by the composition of the Resolutions Committee to which it is assigned, and

WHEREAS, In the past, appointments to each Committee on Resolutions has been made by the president of the Ohio State Medical Association in accordance with Chapter 4, Section 4, of the Bylaws of the Ohio State Medical Association, and

WHEREAS, As a truly democratic organization, the Ohio State Medical Association must make every effort to reflect and enact the desires of its *individual members*, without whom there would be no Ohio State Medical Association, THEREFORE BE IT

RESOLVED, That the power of appointment to Committees on Resolutions be transferred from the president of the Ohio State Medical Association to the delegations from each of the eleven councilor districts, allowing each delegation to appoint one member to each Committee on Resolutions, and BE IT FURTHER

RESOLVED, That the appointment of the members of the Committees on Resolutions be made *after* the assignment of resolutions to committee, so that a delegate who wishes to address himself to a certain resolution will not find himself arbitrarily assigned to serve on another resolutions committee, thus defeating the purpose of his being at the meeting to represent his individual members, and BE IT FURTHER

RESOLVED, That each Committee on Resolutions will elect its own chairman at a meeting attended by every appointed member of that committee, and BE IT FURTHER

RESOLVED, That Chapter 4, Section 4, of the Bylaws of the Ohio State Medical Association be changed to provide that appointments to resolutions committees be made by councilor district delegations instead of by the president of the Ohio State Medical Association.

RESOLUTION NO. 5-74

Dues Increase

(By the Council of the Ohio State Medical Association)

WHEREAS, The Ohio State Medical Association is currently operating at a deficit; and

WHEREAS, The Association is understaffed to meet the obligation to its members; and

WHEREAS, This Association needs now a full-time Department of State Legislation to cope with a State Legislature which is in continuous session; and

WHEREAS, The Association must establish a full-time field service department to bring immediate assistance to the non-metropolitan county medical societies and to strengthen the autonomy of their operations; and

WHEREAS, The rising costs of conducting Association business must be met—postage costs increasing by 18%; travel costs escalating due to fuel problems; paper shortages and rising printing costs—in order to keep communications open; and

WHEREAS, Overly funded state and national governments have organized hundreds of agencies which have turned out millions of words, promulgated countless rules and regulations, generally aimed at developing and implementing plans to take over and control the practice of medicine; and

WHEREAS, Government at legislative, administrative and judicial levels, as well as the public, must hear medicine's answer to the proposals churned out by such agencies; and

WHEREAS, It is necessary to acquire additional staff personnel to work with the Association's committees who develop policies on these proposals for consideration of the House and of the Council; and

WHEREAS, During the next several years costly litigation will be necessary in a number of areas in order to protect the rights of physicians, making necessary the accumulation of funds for legal expense; and

WHEREAS, Modernization of the OSMA membership system to electronic data processing equipment and the word processing system by purchase of an offset press involve considerable capital expenditure; and

WHEREAS, The "word battle" with governmental agencies necessitates the expansion of the Public Relations Department, which now consists of only one staff executive and one secretary, both on a part time assignment to Public Relations; and

WHEREAS, These improvements in the structure of organized medicine must be accomplished forthwith or medicine's house will be destroyed, THEREFORE BE IT

RESOLVED, That the annual dues of active members and associate members be increased to $110, effective January 1, 1975, pursuant to the authority granted to this House of Delegates by Chapter 2, Section 1, of the Bylaws of this Association.

RESOLUTION NO. 6-74

Public Relations Levy

(By the Council of the Lake County Medical Society)

WHEREAS, Progressive pressures from third parties, i.e., insurance carriers, social interests, and malpractice potentials are diverting the energies of formerly and currently practicing physicians and also of available monies from the clinical care of patients, and

WHEREAS, There is every indication that further changes will ensue to increase this diversion to the further detriment of the clinical care of patients unless these pressures are dealt with, and

WHEREAS, The patient is in a much better position, by weight of numbers, to exert effective political counterpressure, and

WHEREAS, The public is apparently relatively unaware of the imminence of further changes and implications of these as hazards for its members' clinical care, NOW THEREFORE BE IT

RESOLVED, That the Committee on Public Relations of the Ohio State Medical Association be instructed to embark on an extensive publicity campaign to inform patients and the public of the hazards to their continuing medical care posed by present and proposed programs, AND BE IT FURTHER

RESOLVED, That the Committee on Public Relations be authorized to request the Council of the Ohio State Medical Association to assess the membership amounts necessary to accomplish this function, such amount not to exceed fifty dollars per member per year.

RESOLUTION NO. 7-74
New Councilor District

(By the Lake County Medical Society)

WHEREAS, We are suburban, rural and contiguous counties whose social, economic and educational problems are similar, and at the same time dissimilar from large metropolitan areas, and

WHEREAS, A single Councilor representing both types of practice would find it difficult to represent the divergent interests of the patients and the physicians involved, and

WHEREAS, The House of Delegates is empowered to approve the creation of Councilor Districts as part of its usual business at the Annual Meeting (Chapter 4, Section 6, page 5, of the Ohio State Medical Association Bylaws), and

WHEREAS, Precedent has recently been set when the involved areas were split up for administrative purposes, and

WHEREAS, There is a common desire on the part of the county societies involved to join together for their mutual benefit, THEREFORE BE IT

RESOLVED, That a new Councilor District be established which would include Ashtabula, Lake and Trumbull counties.

RESOLUTION NO. 8-74
Constitution and Bylaws of OSMA

(By the Huron County Medical Society)

MODIFICATION OF ARTICLE I

WHEREAS, Section 2, Paragraph 7 of Article I "Name and Purposes" of the Constitution and Bylaws of the Ohio State Medical Association reads as follows:

"To study and formulate methods of Health Care Delivery with particular emphasis on efficiency and availability," and

WHEREAS, Effectuating this purpose by Purpose No. 8 which reads

"To carry on such functions and activities as are deemed necessary or desirable to effectuate the above purposes."—may in fact be in violation of Principles of Medical Ethics and the Private Practice of Medicine, THEREFORE BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association amend Article I of the Constitution by eliminating Purpose No. 7 of Section 2 and, BE IT FURTHER

RESOLVED, That a copy of this resolution be sent to all the component County Medical Societies of the Ohio State Medical Association.

RESOLUTION NO. 9-74
Information and Education Serve Freedom

(By the Huron County Medical Society)

RESOLUTION NO. 10-74
Professionalism

(By Alford C. Diller, M.D., Delegate, Van Wert County Medical Society)

RESOLUTION NO. 11-74
To Commend the Ohio Foundation for Medical Care

(By John N. Meagher, M.D., Delegate, Academy of Medicine of Columbus and Franklin County)

RESOLUTION NO. 12-74
Affiliate Membership

(By John J. Gaughan, M.D., Fifth District Councilor and the Academy of Medicine of Cleveland)

WHEREAS, Medical society executives are closely affiliated to the medical profession through their service to medical organizations, and

WHEREAS, Medical society executives have demonstrated their loyalty to the ideals and policies of medical organizations and the profession, and

WHEREAS, The American Medical Association in recognition of this service has admitted medical society executives to affiliate membership in the A.M.A., THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association create a class of membership to be called "Affiliate Members," and BE IT FURTHER

RESOLVED, That executives of the OSMA, county medical societies, and other medical organizations and specialty societies in Ohio be eligible for Affiliate Membership in the Ohio State Medical Association, and BE IT FURTHER

RESOLVED, That Article III, Section I of the Constitution be amended by adding (7) "Affiliate Members", and BE IT FURTHER

RESOLVED, That Chapter I, Section II of the Bylaws be amended to add paragraph (h) "Affiliate Members." Executives of the Ohio State Medical Association, county medical societies and other medical organizations and specialty societies in Ohio are eligible for "Affiliate Membership" in the Ohio State Medical Association. Such "Affiliate Membership" shall be at the pleasure of The Council of the Ohio State Medical Association.

RESOLUTION NO. 13-74
Professionalism

(By the Academy of Medicine of Lima and Allen County)

RESOLUTION NO. 14-74
Governor's Task Force on Health Care

(By the Summit County Medical Society)

RESOLUTION NO. 15-74
Budget Publication

(By the Academy of Medicine of Cincinnati)

WHEREAS, The members of the Ohio State Medical Association are deeply concerned about the finances of this organization, especially in regard to increasing Dues; and

WHEREAS, The membership of this organization should be the final source in the consideration of the expenditure of their monies; and

WHEREAS, The local Councilor-Districts represent the membership in the local action of the organization; THEREFORE BE IT

RESOLVED, That Chapter 7, Section 5 of the Constitution and Bylaws of the Ohio State Medical Association be amended to make mandatory and authorize the publication of the disbursements set forth in the proposed Budget and released prior to the Annual Meeting of the House of Delegates.

(Continued on Next Page)

RESOLUTION NO. 16-74
Compulsory Post Graduate Medical Educational Program
(By the Academy of Medicine of Cincinnati)

RESOLUTION NO. 17-74
To Reject PSRO
(By the Delaware County Medical Society)

RESOLUTION NO. 18-74
Professional Standards Review
(By the Erie County Medical Society)

RESOLUTION NO. 19-74
Preadmission Certification
(By the Erie County Medical Society)

RESOLUTION NO. 20-74
Standardized Insurance Form
(By the Lorain County Medical Society)

RESOLUTION NO. 21-74
Rejection of PSRO and MAI
(By the Mahoning County Medical Society)

RESOLUTION NO. 22-74
AMA Efforts to Repeal PSRO
(By the Mahoning County Medical Society)

RESOLUTION NO. 23-74
Noncompliance with PSRO
(By the Ross County Medical Society)

RESOLUTION NO. 24-74
Abolish MAI
(By the Ross County Medical Society)

RESOLUTION NO. 25-74
Support AAPS Court Test of PSRO
(By the Ross County Medical Society)

RESOLUTION NO. 26-74
Public Opinion and PSRO
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 27-74
MAI and PSRO
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 28-74
OSMA Support for Repeal of PSRO Law
(By the Mahoning County Medical Society)

RESOLUTION NO. 29-74
PSRO
(By the Stark County Medical Society)

RESOLUTION NO. 30-74
PSRO and the Ohio Legislature
(By the Huron County Medical Society)

RESOLUTION NO. 31-74
OSMA and Medical Advances Institute
(By the Huron County Medical Society)

RESOLUTION NO. 32-74
PSRO Unconstitutional-OSMA to Sue HEW
(By the Huron County Medical Society)

RESOLUTION NO. 33-74
H.R. 9375 and 11394—To Repeal PSRO
(By the Huron County Medical Society)

RESOLUTION NO. 34-74
MAI Peer Review System
(By the Academy of Medicine of Lima and Allen County)

RESOLUTION NO. 35-74
Repeal of P.L. 92-603
(By the Wayne County Medical Society)

RESOLUTION NO. 36-74
Repeal of Prenatal Gonorrhea Testing
(By the Stark County Medical Society)

RESOLUTION NO. 37-74
Comprehensive Health Education in Ohio's Public Schools
(By the Academy of Medicine of Cleveland and Fifth District Councilor, John J. Gaughan, M.D.)

RESOLUTION NO. 38-74
Welfare Department Payments
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 39-74
National Health Insurance
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 40-74
Common Cause
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 41-74
Day of Protest
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 42-74
Let Money Follow People
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 43-74
Sports Medicine Commendation
(By the Jefferson County Medical Society)

RESOLUTION NO. 44-74
Assignment Via "Healthcard"
(By C. G. Madsen, Jr., M.D., Delegate Lake County Medical Society)

RESOLUTION NO. 45-74
Out-Patient Diagnostic Procedures
(By the Huron County Medical Society)

RESOLUTION NO. 46-74
Liability Would Shift to the Provider
(By the Huron County Medical Society)

RESOLUTION NO. 47-74
Medical Coupons
(By the Huron County Medical Society)

RESOLUTION NO. 48-74
Repeal of the Changes in the Ohio Prenatal Testing Law
(By John H. Sanders, M.D., Delegate, Academy of Medicine of Cleveland)

RESOLUTION NO. 49-74
Constitutional Amendment on Abortion
(By John H. Sanders, M.D., Delegate, Academy of Medicine of Cleveland)

RESOLUTION NO. 50-74
Bureau of Crippled Children's Services
(By the Academy of Medicine of Columbus and Franklin County)

Executive Director Named by Columbus Academy of Medicine

New Executive Director of the Academy of Medicine of Columbus and Franklin County is James S. Imboden who assumed that office on March 15. The change in the administrative setup of the organization was announced by William C. Earl, M.D., Academy President, following a meeting of the governing board in February.



James S. Imboden

For the past nine years, Mr. Imboden has been employed by the American Medical Association as Assistant Director, Field Service Department, Public Affairs Division, to work with the states of Ohio, Michigan, West Virginia and Virginia with offices in Columbus.

Mr. Imboden, before moving to Columbus in 1965, was for six years on the executive staff of the Kansas Medical Society with offices in Topeka.

A 1950 graduate of Washburn University, Topeka, Kansas, Mr. Imboden also attended Kansas State University, Manhattan, for his graduate work in the field of education.

Following graduation from college, Mr. Imboden was employed by the Topeka Chamber of Commerce as Director of the Chamber's Civic Affairs Division, Convention Bureau, Membership and Military Affairs Committees.

Imboden and his wife and three children reside at 1827 Cambridge Blvd. in the Columbus suburb of Upper Arlington. He is an active member of the American Association of Medical Society Executives and the Ohio Association of County Medical Executives.

As chief executive officer of the Academy, Mr. Imboden fills the office made vacant by the resignation of W. "Bill" Webb, Jr., who served the Academy in that capacity for 18 years. Mr. Webb resigned for health reasons on the advice of his physician.

In addition to his duties with the Academy, Mr. Webb has been active in several organizations related to his work. He is a past president of the Association of County Medical Executives and formerly served as that organization's program chairman. He is a member of the American Association of Medical Society Executives and formerly served as the AAMSE's membership chairman. Among other memberships, he belongs to the Ohio Trade Association Executives.

Federal Funds Again Requested for OSU Medical Center Expansion

Ohio State University is submitting a new request for $17.5 million in federal construction funds for expansion of University Hospital.

Ohio State's Board of Trustees early in March directed that the grant application be filed with the Secretary of Health, Education and Welfare under Title VII of the U.S. Public Health Service Act.

Approval of the grant would reinstate a $38-million project for a proposed ten-floor in-patient teaching facility and expansion of the service areas of the existing University Hospital.

A previous application by Ohio State for $22 million for the Clinical Medical Sciences Education Facility received approval of the National Advisory Council on Education for Health Professions in 1970, but the project was not funded. The HEW Secretary now has announced availability of new funds from 1973 and 1974 federal appropriations, University officials reported.

Prior to this recent HEW announcement, the university's trustees on December 7 had acted to proceed only with top-priority needs of the original project, financed through $10 million currently available in appropriated state funds. The board made provisions, however, to move ahead with other phases of the project whenever federal support was obtained. Addition of the new federal funds and some $10 million raised through self-liquidating bonds to be retired through hospital income would restore the project to its original size.

The expansion site would be south of and parallel to the present University Hospital.

BUDGET FOR 1974

Ohio State Medical Association

Adopted by The Council at its regular meeting December 15-16, 1973.

The Ohio State Medical Journal (10,200 members @ $4.50)		$ 45,900.00
Executive Salaries		140,100.00
Staff Expense		22,000.00
Staff Associate, Secretarial and Clerical Salaries		105,800.00
President:		
1973-1974	Expense $3,500.00	
	Honorarium .. 5,000.00	
1974-1975	Expense 3,500.00	
		12,000.00
President-Elect:		
1973-1974	Expense $2,500.00	
	Honorarium .. 2,000.00	
1974-1975	Expense 2,500.00	
		7,000.00
Past-President:		
1973-1974	Honorarium .. $2,000.00	
		2,000.00
Secretary-Treasurer:		
	Honorarium .. $2,000.00	
		2,000.00
Council Expense		18,500.00
AMA Del-Alt Expense (per diem $36.00; Ground Travel $40.00)		20,000.00
Committees:		
Auditing and Appropriations		4,000.00
Cancer		300.00
Emergency & Disaster Medical Care		750.00
Education		2,000.00
Environmental and Public Health		500.00
Eye Care		400.00
Government Medical Care Programs		1,000.00
Health Care of the Poor		200.00
Hospital Relations		500.00
Insurance		1,100.00
Jails and Prisons		200.00
Judicial and Professional Relations		250.00
Laboratory Medicine		200.00
Liaison Comm. to Nationwide Insurance		200.00
Manpower		500.00
Maternal Health		2,400.00
Medicine and Religion		200.00
Membership and Planning		500.00
Mental Health		2,000.00
Nursing		150.00
OSMA-OSBA Liaison		850.00
Organ Transplant		400.00
Placement Service		350.00
Podiatry Relations		200.00
Private Practice		750.00
Public Relations		400.00
Rehabilitation		100.00
Rural Health		1,500.00
School Health		5,000.00
Scientific Work		600.00
Workmen's Compensation		250.00
Annual Meeting		76,300.00
Building Expense (Mtge. amortization, ins., maint. etc.)		50,000.00
Car Lease Expense		7,200.00
Councilor District Conferences		5,000.00
Data Processing		24,000.00
Emergency Fund		10,000.00
Equipment Rental		12,000.00
Family Practice Scholarships		4,000.00
Insurance and Bonding		17,000.00
Legal Expense		25,000.00
Library		750.00
OSMAgram		7,500.00
Postage		14,500.00
Professional Relations Activities		5,000.00
Public Relations Dept: Information Materials		1,000.00
Public Relations Dept: Misc. Activities		5,000.00
Rent		16,000.00
Moving Expense		3,000.00
Stationery, Printing and Supplies		12,500.00
Taxes: Payroll		15,000.00
Telephone and Telegraph		10,000.00
Depreciation		12,500.00
Furniture and Equipment		25,000.00
TOTAL BUDGETED FOR 1974		$761,300.00

NEW! Patient Therapy Packs

Because many patients tend to stop treatment prematurely, the full course of b.i.d. therapy is now specially packaged to encourage patients to complete the full course of therapy.

CANDEPTIN Vaginal Ointment Therapy Pack– two 75 gm. tubes

CANDEPTIN Vagelettes Therapy Pack–28 vaginal capsules

CANDEPTIN Vaginal Tablet Therapy Pack–28 vaginal tablets

Brief Summary

Description: CANDEPTIN (Candicidin) Vaginal Ointment contains a dispersion of Candicidin powder equivalent to 0.6 mg. per gm. or 0.06% Candicidin activity in U.S.P. petrolatum. 3 mg. of Candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain Candicidin powder equivalent to 3 mg. (0.3%) Candicidin activity dispersed in starch, lactose and magnesium stearate.

CANDEPTIN VAGELETTES Vaginal Capsules contain 3 mg. of Candicidin activity dispersed in 5 gm. U.S.P. petrolatum.

Action: CANDEPTIN Vaginal Ointment, Vaginal Tablets, and VAGELETTES Vaginal Capsules possess anti-monilial activity.

Indications: Vaginitis due to *Candida albicans* and other *Candida* species.

Contraindications: Contraindicated for patients known to be sensitive to any of its components. During pregnancy manual Tablet or VAGELETTES Capsule insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution: During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.

Adverse Reaction: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment, Vaginal Tablets or VAGELETTES Vaginal Capsules have been extremely rare.

Dosage: One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet or one VAGELETTES Vaginal Capsule is inserted high in the vagina twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Available Dosage Forms: CANDEPTIN Vaginal Ointment is supplied in a Patient Therapy Pack, containing two 75 gm. tubes with two applicators for the full course of treatment. CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil with inserter – enough for a full course of treatment. CANDEPTIN Vagelettes Vaginal Capsules are packaged in a Patient Therapy Pack, containing 28 CANDEPTIN Vagelettes Vaginal Capsules (2 boxes of 14), for the full course of treatment. Store under refrigeration to insure full potency.

Federal law prohibits dispensing without prescription.

References:

1. Melges, F. J.: Obstet. Gynecol. *24*:921, Dec. 1964. **2.** Cameron, P. F.: Practitioner *202*:695, May 1969. **3.** Olsen, J. R.: Journal-Lancet *85*: 287, July 1965. **4.** Giorlando, S. W.: OB/GYN Digest *13*:32, Sept. 1971. **5.** Decker, A.: Case Reports on file, Medical Department, Julius Schmid. **6.** Friedel, H. J.: Md. State Med. J. *15*:36, Feb. 1966. **7.** Roberts, C. L. and Sullivan, J. J.: Calif. Med. *103*:109, Aug. 1965. **8.** Giorlando, S. W., Torres, J. F. and Muscillo, G.: Am. J. Obstet. Gynecol. *90*:370, Oct. 1, 1964. **9.** Abruzzi, W. A.: Western Med. *5*:62, Feb. 1964.

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- *Exact dosage assured* when used as directed.
- *High patient acceptability*, easy to use in all forms; helps keep patients on the full 14-day regimen—important in controlling recurrences.
- *Clinically proved*—CANDEPTIN Vaginal Ointment and Vaginal Tablets have more than nine years of clinical experience.
- Sensitivity and temporary irritation with CANDEPTIN (candicidin) Vaginal Ointment, Vaginal Tablets, and VAGELETTES Vaginal Capsules have been extremely rare.

And a dosage form for all your patients



VAGELETTES™ Vaginal Capsules

Vaginal Ointment

Vaginal Tablets

Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

GOING MY WAY? **That** way leads to Cleveland and the thirty-fourth annual convention of the Woman's Auxiliary to the Ohio State Medical Association May 13, 14 and 15. The scene of activity will be the Statler Hilton. We talked about some of it last month; now there's more to say!

First, because it is a very important meeting; second, because it is offering a terrific program that is a happy combination of work and play; third, because it is such a wonderful opportunity for doctors' wives all over the state to get together and to "get to know you." The official business sessions will be on Tuesday morning, May 14 and Wednesday morning May 15. These sessions will, of course, be presided over by Mrs. Karl Ulicny, state president. The convention theme this year is "The Focus Is On You."

Honored guest will be Mrs. Erle E. Wilkinson, of Nashville, Tenn., who is first vice-president of the Woman's Auxiliary to the American Medical Association. She will address the House of Delegates and install the 1974-75 officers. The installation will take place Wednesday morning and at 11:30 a.m. there will be a reception honoring Mrs. S. J. Glueck, the incoming president, the new officers and Board, at the Cabaret in Playhouse Square where the "Come to the Cabaret" luncheon will be held at 12:30 p.m.

The Central Office, Budget and Resolutions Committees will meet on Sunday, May 12. In keeping with a successful practice inaugurated a few years ago, old and new Board members will participate in the preconvention Board meeting on Monday morning, the 13th. The Board luncheon that day will also include the outgoing and incoming members.

A "first" this year is the combining of the State Board dinner Monday evening, May 13, with that of the Gavel Club (the organization of past state presidents). Husbands are invited to this gala occasion.

Perhaps one of the most important projects at conventiion is the "Job Orientation" program for the 1974-75 county presidents and presidents-elect and State Board members. This will take place on Monday afternoon from two to four. The Sheraton-Cleveland Hotel will be host to the OMPAC luncheon Tuesday at 11:30 a.m. And just by way of reminder, there will be the special Bus Tour: University Circle with tea at the Cleveland Garden Center. And, of course, on Tuesday afternoon at 5:00 there is the reception for county presidents and presidents-elect in the suites of Mrs. Ulicny and Mrs. Glueck.

It takes a lot of work and a lot of people to make a successful convention. We can't begin to name everyone who is participating but we feel we should certainly give the names of the special chairmen (last month we introduced you to Mrs. Thomas L. Manning, convention chairman, and Mrs. F. M. Freimann, convention cochairman):

Finance, Mrs. Joseph Tomashefski; Guests, Mrs. Christopher Colombi; Liaison, Mrs. Paul Sindelar; Hospitality, Mrs. George Leicht; Properties, Mrs. Nicholas Demmy; OMPAC Luncheon Decorations, Mrs. Frank Meany; Pages, Mrs. George Spencer; Printing, Mrs. Robert Perchan; Publicity, Mrs. Ignacio LaHoora and Mrs. Vincent LaMaida; Registration, Mrs. Fred Kelly and Mrs. Joseph Corsaro; Roll Call, Mrs. Robert Kapp; Sponsors, Mrs. Edward Kieger, Sr.; Tickets, Mrs. R. McDonald; President's Breakfast, Mrs. Ronald Chapnick; Wednesday Luncheon, Cuyahoga Gavel Club, Mrs. R. J. Kennedy and Mrs. Myron Perlich; Early Bird Prizes, Mrs. Paul Chrenka; Cover Design, Mrs. A. F. Naji.

"One-Liners"

With the support of OSMA, a special conference "Ohio's Campaign to Prevent Child Abuse and Neglect, the Medical Perspective," will be held Wednesday, April 24 at the Holiday Inn Downtown, Columbus. . . . **Butler County** auxiliary called upon its doctors to share in an "Old-Fashioned Talent Night" February 20 at the Elks Club in Hamilton. . . . **Cuyahoga** auxiliary hostessed a Christmas party for the children of foreign doctors. . . . Power Mower Safety was the theme of a recent meeting of the **Erie County** group. . . . "Tell Me Your Troubles" featured the January meeting of the **Franklin** auxiliary as presented by Ms. Nodine C. Henniger, Ombudswoman for the City of Columbus. . . . The **Jefferson** group had its second annual International Night dinner recently at the Royal Pavilion at which a new cook book produced by the auxiliary was sold. . . . **Lucas County's** April meeting was a "Big Bridge Lucheon" for the benefit of AMA-ERF at the Sheraton Westgate. . . . "Party Night" was the extra-special "production" of the **Stark County** auxiliary on February 23 at the Shady Hollow Country Club at which a lucky couple won a free trip to Las Vegas. . . . **Scioto County's** February meeting at the home of Mrs. George Obrist featured as guest speaker Anna Louise Stanton who spoke on "Scioto County's People Who Matter."

Going My Way? Then I'll be seeing you in Cleveland, come May. . . .



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during January. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

BUTLER
Terry G. Hunt
Oxford
Ricardo P. Mesina
Oxford

CUYAHOGA
Denis I. Becker
Cleveland
Thomas K. Rawa
Cleveland

CLARK
Simeon J. Palomino
Springfield

LAKE
Armin J. Green
Mentor
Jaya R. Shah
Willoughby

MEDINA
William Denny Robertson
Medina

MONTGOMERY (Dayton)
William H. Burba
Sunder Lal Goel
Henry N. Maimon
Nola Jones Palomino
Farouk A. J. Tabrah

MUSKINGUM
Thomas N. Ruggles
Zanesville
Nick A. Sarap
Zanesville

STARK
Gerald E. Smith
Canton

Lions Eye Research Funds

The Ohio Lions Eye Research Foundation, which has aided the work of the Department of Ophthalmology at the University of Cincinnati College of Medicine for more than two decades, has made another gift of $23,500.

Since the Lions Foundation inaugurated its support program in 1952, it has distributed more than $1 million in funds for eye research at UC, Ohio State University and Case-Western Reserve University, and, for the first time this year, to the University of Toledo. The money comes from voluntary donations by the state's 520 Lions clubs.

UC has now received a total of $216,000 from the Lions Foundation.

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In This Issue:

Abbott Laboratories 262

Allergy Laboratories of Ohio 210, 245

The Brown Pharmaceutical Co., Inc. 224, 244, 276

Burroughs Wellcome Co. 247

Daniels-Head & Associates, Inc. 219

Dorsey Laboratories, Div. of Sandoz-Wander, Inc. 207, 250, 273

Flint Laboratories, Div. of Travenol Lab., Inc. 228-229

Harding Hospital 276

Lilly, Eli and Company 230

McNeil Laboratories 209

Mead Johnson Laboratories 225

The Medical Protective Co. 224

Merck, Sharp & Dohme, Div. of Merck & Co, Div. Inc. 220-221-222

Pharmaceutical Manufacturers Association 260-261

Robins, A.H., Company 217-218

Roche Laboratories, Div. of Hoffman-LaRoche, Inc. .....Inside Front Cover-205, Inside Back Cover and Back Cover

Wm. H. Rorer, Inc. 211

Julius Schmid, Inc. 282-283

Searle Laboratories, Division of G.D. Searle & Co. 248-249

SK&F Co., Subsidiary of Smith, Kline & French Laboratories 259

The Upjohn Company 274-275

U.S. Air Force 213

Video Record, Inc. 272

Wendt-Bristol Co. 242

Windsor Hospital 246

Wolman Insurance Agency, Inc. 223

Classified Advertisements

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FAMILY PRACTITIONER—north central rural Ohio, new office and hospital, financial arrangements are open. Box 707, c/o Ohio State Medical Journal.

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DIRECTOR—DIVISION OF PREVENTIVE MEDICINE—Unusual opportunity with dynamic City Health Department offering Administrative and Clinical duties and academic appointment in major medical center. Physician licensed or eligible for licensure in State of Ohio. Board certified or Board eligible in Pediatrics, Internal Medicine or Preventive Medicine with training or experience in Infectious Disease Control and Epidemiology. Salary $31,500. Write including resume to Arnold M. Leff, M.D., Assistant Commissioner, P.O. Box 238, Cincinnati, Ohio.

Family Practice Director Named at Ohio State

Appointment of Tennyson Williams, M.D., as director of the Division of Family Practice, a step toward establishment of a new department in the College of Medicine at Ohio State University, received the approval early in March of the University's Board of Trustees.

Dr. Williams currently specializes in family practice in Delaware, and is a clinical instructor in Ohio State's Department of Preventive Medicine.

In the division directorship, his assignment initially will include responsibility for development of an academic department of family medicine at the university.

The appointment follows recommendations made by a Family Practice Program Development Committee, set up in the College of Medicine in 1972. The committee's report last June underlined the need for a department of family medicine.

Dr. Williams assumes the directorship of the division April 1, serving on a halftime basis until June 14.

A member of the American Academy of Family Practice since 1953, Dr. Williams served as chairman of the Medical School Family Practice Committee (now called Undergraduate and Graduate Medical Education Committee) from 1967-73.

He is a member also of the Society of Family Teachers of Medicine, the Ohio State Medical Association, the Delaware County Medical Society, the Delaware County Academy of Family Physicians, the Ohio Thoracic Society and the Ohio State University Medical Society.

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Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

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PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

VOLUME 70 MAY 1974 NUMBER 5

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MAY 21 1974

Original Articles

Diagnostic Peritoneal Lavage in Acute Abdominal Problems. William R. Schiller, M.D., Toledo, and John H. LaVoo, M.D., Nellis Air Force Base, Nevada 313

Evaluation of McKeever Tibial Plateau Arthoplasty of the Rheumatoid Knee. Richard A. Freiberg, M.D., Cincinnati, and Paul W. Welch, M.D., Canton 316

Lead Encephalopathy. Report of a Case Associated With Industrial Exposure. Miguel A. Pedraza, M.D., and Frank Anzinger, M.D., Springfield 319

Letters to the Editor 321

Your State Society at Work

New Members of OSMA 296

What The OSMA Council Did at Its March 9-10 Meeting 323

Your State Association Committees at Work 332

Uterine Cancer Project Receives OSMA Endorsement 332

1974 OSMA Annual Meeting

A Message from the President: A Common Interest with Your Colleagues 338

Athletic Team Physicians To Be Honored by Annual Meeting Exhibit 334

Your AMA at Work

Dr. Sammons To Be AMA Executive Vice-President 290

Ohio's AMA Delegates Meeting Report 334

State Medical Board

Toledo Physician Named to State Medical Board 336

Medical Advances Institute

Medical Advances Institute, Its Functions and Responsibilities as Discussed by Its President and Directors of Clinical Systems 292

Ohio Medical Political Action

Support for OMPAC-AMPAC Vital This Election Year 340

Ohio Medical Indemnity

OMI Highlights of Operations for the Year 304

Keeping Up

Continuing Medical Education Courses for Physicians in Ohio 342

Woman's Auxiliary

Auxiliary Members Look Forward to National Meeting in Chicago 341

Other Features

Optimal Criteria Studies Available from Commission on Accreditation 290

MDs in the News 302

Cleveland Clinic to Share in CHD Study 308

Obituaries 311

The Journal's Advertisers

The Journal's Advertisers in This Issue 344

Classified Advertisements 345

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Published manthly under the direction at The Council far and by members at The Ohia State Medical Assaciatian, 17 Sauth High Street, Suite 500, Calumbus, Ohia 43215, a scientific society, nanprafit arganization, with a detinite membership far scientific and educatianal purpases.

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Entered as secand class matter July 5, 1905, at the Past Office at Athens, Ohio, under the Act at Congress at March 3, 1879. Acceptance for mailing at special rate at pastage pravided far in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Secand-Class Pastage Paid at Athens, Ohio.

The Jaurnal daes nat assume respansibility far opinians expressed by the essayists. Advertiser must canfarm ta palicies and regulatians established by The Cauncil at the Ohia State Medical Assaciatian.

Publicatian attice: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

Dr. Sammons, To Be AMA Executive Vice-President

The Board of Trustees of the American Medical Association recently announced the appointment of James H. Sammons, M.D., as the future Executive Vice-President.

The post of Executive Vice-President is the top administrative position at the AMA. Doctor Sammons will succeed Ernest B. Howard, M.D., who has been EVP since March 1969. Doctor Howard will reach retirement age early next year.

Doctor Sammons, a family physician in Baytown, Texas, became Chairman of the AMA Board of Trustees in October 1973. Previously he had served as its vice-chairman for one year.

He has been succeeded as Chairman by Richard E. Palmer, M.D. of Alexandria, Va., who has served as vice-chairman since late 1973. John M. Chenault, M.D. of Decatur, Ala., was elected the new vice-chairman.

Optimal Criteria Studies Available from Commission

The Joint Commission on Accreditation of Hospitals (JCAH) has announced the release, in printed form, of two year-long studies which index hospital-based capabilities to provide various levels of care for patients with heart disease or cancer.

The studies, which were contracted for by the Department of Health, Education and Welfare, Regional Medical Programs Service (RMPS), were undertaken by the Joint Commission's Listing Program for Specialized Clinical Services (LP/SCS). The heart and cancer studies, along with previously completed studies on kidney disease and stroke, complete the present contract.

The last two studies, "Optimal Criteria for Care of Heart Disease Patients," and "Optimal Criteria for Care of Patients with Cancer," appeared respectively in the December 10 and January 7 issues of *The Journal of the American Medical Association.*

Copies of the heart and cancer studies, as well as the kidney and stroke studies, are available at no charge from John D. Porterfield, M.D., Director, Joint Commission on Accreditation of Hospitals, 875 North Michigan Ave., Chicago, Illinois 60611.

Dr. Claude Frazier is continuing his study of allergic reactions to biting insects and requests that physicians send him applicable case reports. Information should be addressed as follows: Claude A. Frazier, M.D., 4-C Doctor's Park, Asheville, N. C. 28801.



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Medical Advances Institute

By Robert R. Clark, M.D., and Paul Y. Ertel, M.D.

MEDICAL ADVANCES INSTITUTE (MAI) from its inception has endeavored to function in a manner that demonstrates its responsibility to the House of Delegates and The Council of the Ohio State Medical Association (OSMA). At all times MAI has attempted to interpret and implement the will of the physicians of Ohio in discharging their obligations to the patients in their care. All resolutions adopted by the OSMA House of Delegates have served as the guidelines within which MAI must function. Presently, MAI has adapted its operation to the dictates of Resolution 29-73, adopted by the 1973 OSMA House of Delegates.

This resolution concerned itself with the Professional Standards Review concept legislated by P.L. 92-603. This was somewhat in conflict with the basic premise of MAI. The primary purpose and direction of the MAI program was to develop a uniform peer review system to be implemented in the State of Ohio to evaluate the quality, quantity and cost of the medical care delivered to **all** patients. Limiting MAI to the PSRO program is a violation of the original charge. Labelling MAI as PSRO is an injustice and suggests an inaccurate implication. MAI was not conceived nor designed to function merely as a Professional Standards Review instrument. The MAI-Peer Review System can be adapted to serve the requirements demanded of a PSRO group, but it must be emphasized that this is only one of the functions of MAI.

MAI Different from PSRO

Both officers and personnel of MAI have been deeply concerned that MAI and PSRO are becoming synonymous throughout this state. A great deal of effort has been expanded to demonstrate that indeed there is a vast difference between PSRO and a uniform, objective peer review system. Limited time, resources and personnel have restricted the educational efforts needed to correct some apparent apprehensions and misconceptions. Facts show that MAI is not a tool of any government—federal, state or local.

MAI officers and personnel in discharging their responsibilities to OSMA Resolution 29-73 have met with federal officials many times. Their meetings have been concerned with all facets of P.L. 92-603 and with infinite energy expended upon area designation proposals. At no time was there hesitancy in expressing negative attitudes about specific sections of the law and regulations published in the Federal Register. The will of the OSMA House of Delegates and the statement of the President of OSMA, Oscar W. Clarke, M.D., read before the AMA House of Delegates have been conveyed to HEW, emphatically.

MAI Makes Its Point with HEW

Demonstration of the effectiveness of the dialogue is that HEW has accepted the twelve regions (area) proposed by MAI, rather than the nine areas originally designated by the Secretary of HEW. As a bonus, presumably, the numbering of the areas has been changed so that they coincide with the OSMA numerical designation of councilor districts. Because of the number of physicians in Cuyahoga County, MAI recommended that this county be designated as the twelfth region (area) in Ohio. This has been recognized.

OSMA House of Delegates Resolution 29-73 advocates a single statewide area designation under the MAI program of peer review. As far back as 1971, MAI proposed the twelve-region concept operating under a state organization support system—umbrella, if you will. This "umbrella" approach was logical in that it supplied technical and administrative support to local autonomous societies and organizations. This technique was rejected by the federal authorities and a state area wide approach was necessary.

The name "umbrella" is unacceptable, but the same approach has been developed by the Secretary of HEW. MAI can serve the twelve areas as a support service research organization. The twelve areas promulgated and obtained by MAI can, again, be united under an "umbrella," but with another name—support service. MAI, then, can be a resource, technical, development

Dr. Clark is President of MAI
Dr. Ertel is MAI's Director of Clinical Systems

and support organization to assist regional (area) medical groups in creation, development, support and administratoin of a PRS corporation, which if desired locally, can qualify to provide effective. efficient peer review.

No Rushing into Contract

MAI has been offered the opportunity by federal (HEW) authorities to accept a contract to be the support service organization in the State of Ohio for all of the area peer review organizations. Let it be clearly understood that MAI has not signed any agreements to perform in this role, nor has MAI accepted monies for any purpose from the federal government. Even though OSMA House of Delegates Resolution 29-73 encourages such action in the second resolve, the officers of MAI believe that cautious, deliberate consideration must be given before a definitive course is pursued.

In support of this attitude, the following policy statement was adopted in March by the MAI Board of Trustees:

> "Some PSRO sections of P.L. 92-603 are not acceptable to the medical profession. MAI, through all resources, should exert influence to modify the law and regulations and continue efforts to develop a sophisticated peer review system assuring quality care for all patients."

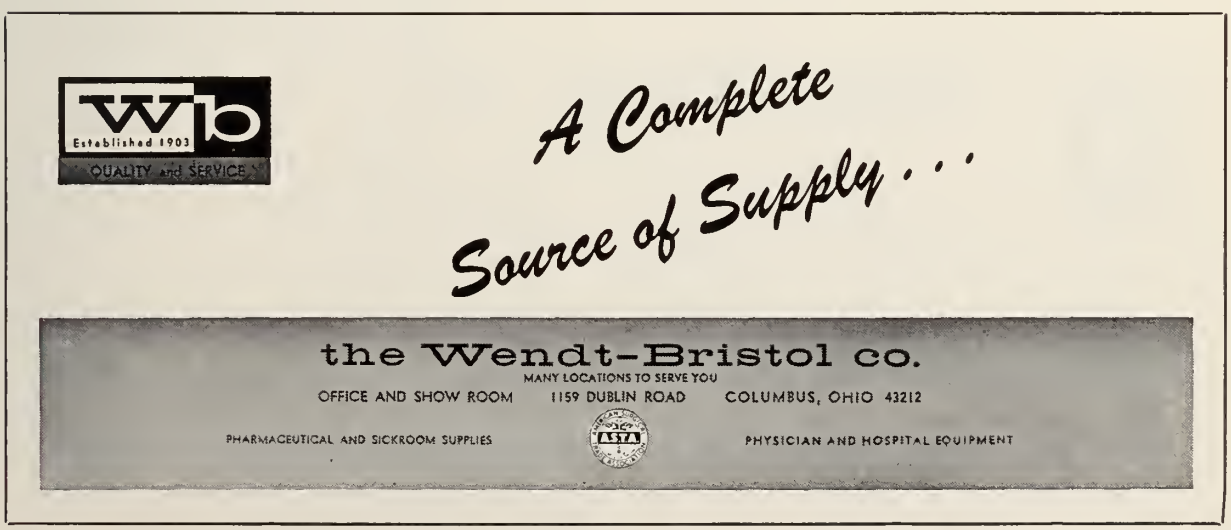
Alternative courses of action are being considered in depth so that an effective, uniform quality review can be conducted for all patients, regardless of their financial reimbursement source. The officers of MAI are proceeding with extreme circumspection.

Wide Interest in System

MAI has continued to work diligently to provide a sophisticated peer review system that will serve all patients and physicians in Ohio. A great deal of active interest in this MAI-PRS method has been expressed by many organizations desiring to employ this system in other parts of the country. Interest from such organizations as AMA, CPHA and G. D. Searle seems to be testimony to the excellence of the program.

More than 250 "model" disease specific criteria have been developed and refined in computer-adaptable format by the many specialty panels. These criteria are in the final stages of editing and programming. When the processing has been completed, these "model" criteria will be made available to the local peer groups and hospital staffs. These "model" criteria can easily be modified to meet the needs of local groups and staffs in performing true peer review at the local level. The development of "model" criteria by the MAI specialty panels greatly reduces physician time and manpower necessary to create multiple criteria sets in this state. Modification of model criteria requires a great deal less time than the creation of such criteria.

These disease specific criteria are presently being evaluated in 27 pilot institutions sponsored by MAI. This experience has already resulted in deletion and correction of many data elements originally requested by the panels. Programming for the exception reports to be evaluated by peer physicians has been completed. Presently, MAI physicians in the pilot institutions are evaluating and segregating these exception reports in order to reduce physician time needed in the peer review process. Educational and indoctrination pro-



grams for hospital staffs are being developed, currently, to be initiated by hospital staff committees. With the completion of this phase, the peer review package advocated by the House of Delegates will have been accomplished.

An objective study of the peer review program created by MAI will, indeed, demonstrate that this system is designed to evaluate the quality of medical care provided to all patients. Cost containment considerations are not the basic elements or purpose for this system. Surely some cost will be diminished as a by-product of improving quality of care and establishing the necessity for such care.

Programmed for Future Needs

The potential of this peer review system in identifying and fulfilling educational needs is unlimited. Without question, this program can be utilized to meet the continuing educational requirements which may soon be mandatory for all physicians. MAI will provide monthly summary data in several categories to the hospital staff administration to be used for development of physician educational program.

Concurrent information is available to the attending physician as well as to the hospital staff physicians. Such data controlled by audit trails programmed into the computer will most assuredly result in objective appraisal of the quality of care being given to each individual patient.

The OSMA House of Delegates has charged the officers of MAI to create and develop a peer review system that can be employed in all regions of this state. The creation of a uniform peer review system and data collection method relieving local physicians of this laborious task has been accomplished. In addition, a supportive resource organization has been developed to assist medical groups in the performance of effective peer review. Acceptance and employment of this peer review system by physicians throughout the state may well be the "ultimate" weapon in forestalling both federal and state government invasion of strictly professional matters.

OSMA Resolution 29-73, with its reference to a statewide area designation, urges a solidarity and unity in the approach to peer review. This indicates that strength and defense of common principles can be achieved through a single instrument. Apparently local needs seem to dictate the necessity for unilateral action which leads to fragmentation of the entity designed to provide strength and support for all elements. Precipitous action, not controlled by objective appraisal of the problems faced by all Ohio physicians, must be avoided. MAI has assiduously adhered to the restraints and constraints advised by the House of Delegates. The position of OSMA and all physicians would be more secure were all physician groups more responsive to the dictates of the House. Common purposes must be developed to achieve common goals.



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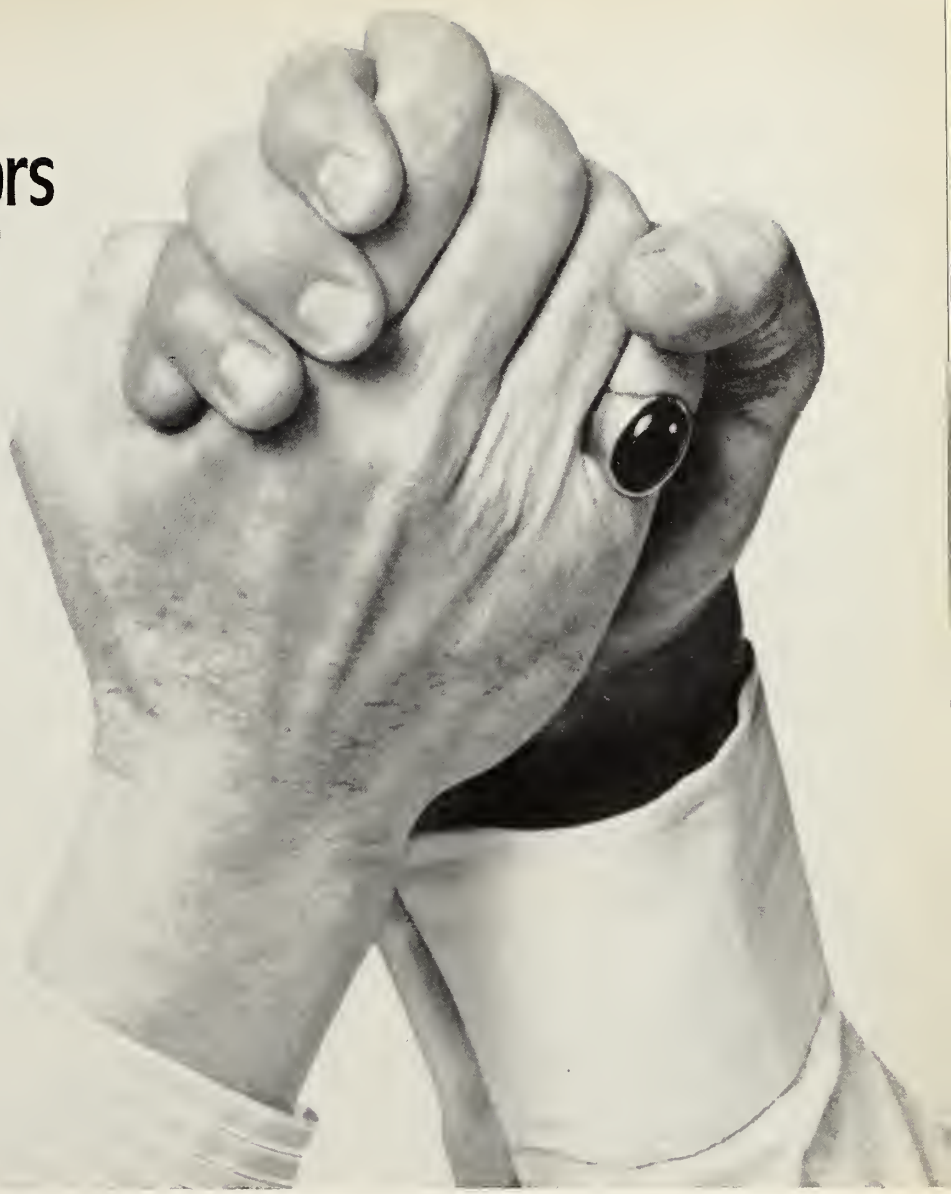
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Must vasodilators and therapy for other diseases come into conflict?



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VASODILAN®
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the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Mead Johnson LABORATORIES



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during January and February. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

ALLEN
William O. Light
Lima
Chen Te Lin
Lima

ATHENS (Athens, except as noted)
Norma A. Flores
Nelsonville
Reuben C. Flores
Nelsonville
Atmaram S. Gawande
Sushlia G. Gawande
Paiboon Isra
William D. Jacoby

ASHTABULA
Jong G. Kim
Ashtabula

BELMONT
Shakir M. Fattah
Bellaire

COLUMBIANA
William A. Graham, Jr.
East Liverpool

CUYAHOGA (Cleveland)
Khushal C. Bhaiji
Teodorico G. Exconde
Grant T. Franklin
Monique V. King
Ruben A. Miguel
Shiridhar M. Pathak
Hsien Chang Wang

ERIE
John Paul Cook
Sandusky
Kyung Hyun Kim
Sandusky

FAIRFIELD
Sue C. Church
Thornville

FAYETTE
Kwok Kuen Wong
Washington C.H.

GREENE (Xenia)
Priyakant K. Desai
Kazem Khoii
Somashekhar S. Patil

HAMILTON
Ralph Rae Minges
Cincinnati
Robert B. Schmidt
Cincinnati

HOCKING
Alfonso Y. Gay
Logan

JEFFERSON
Gumercindo R. Jose
Smithfield

LAKE
Anthony J. Castrovinci
Mentor
Pei Lien Wang
Akron

LICKING
Chang Sup Lee
Newark
William H. Overholser
Granville

LORAIN
Meir Benit
Elyria

LUCAS (Toledo, except as noted)
Samira A. Abbu
Pongchai Apichaisiri
Frank R. Bruening
Robert I. Finkel
Shaik A. K. Jaweed
Rossford
A. Arthur Mancini
Charles V. Perrill
Shang-Youl Rhee
Richard W. Siders
Ira Silberman
Charles M. Smith
Mayer Wainstein
Larry K. Winegar
Dimitrios Xanthakos
Ursula Xanthakos

MARION
Maylinda Mancao
Marion
Tarlok S. Purewal
Marion

MIAMI
Tzy-Shan Lin
Troy
Joseph Miller
Piqua

MONROE
Joseph W. Blevins
Woodsfield

OTTAWA
Barry R. Cover
Port Clinton

PORTAGE
B. V. Hedge
Kent
Cheng-Haw Hung
Garrettsville
R. Vadamalayan
Kent

MONTGOMERY
Walter J. Hill
Dayton
Theodore R. Miller
Dayton

RICHLAND
Kali S. Haldar
Mansfield

STARK
Allen Tulgan
Canton
Paul W. Welch
Canton

TUSCARAWAS
Loreto R. Dacio
Dover
Edgardo R. Kagaoan
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Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.



INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

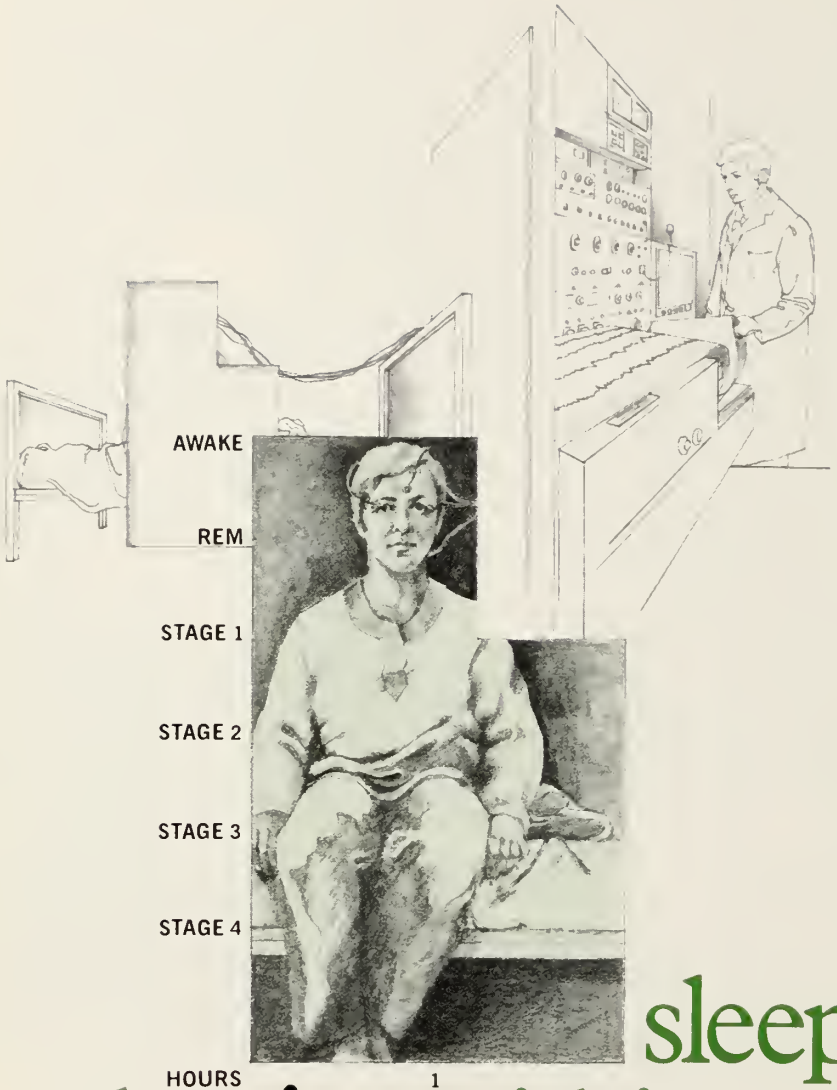
NEOSPORIN® Ointment

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packets.

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sleep begins within 17 minutes, on average ...

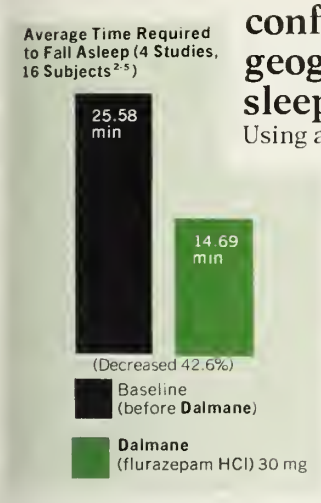
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

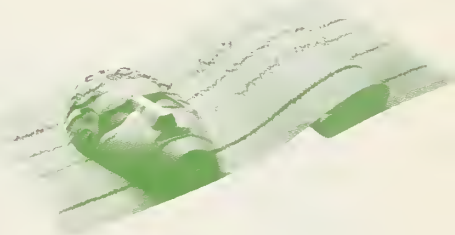
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- **induces sleep within 17 minutes, on average**
- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare



A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

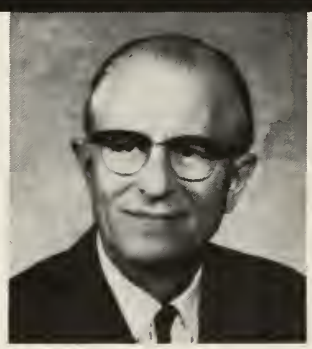
What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it, for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the necessity

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company



A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year.

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It

for a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful. On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

---

should in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical
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MDs in the News

Dr. John S. Collis, a member of the Cleveland Clinic's Department of Neurological Survey and Head of its Section of Spinal Surgery, has been elected president of the Northeast Ohio Neurosurgical Society to succeed Dr. Thomas Tank of St. Vincent's Charity Hospital. Other officers installed this year include Dr. Ed Shannon, affiliated with Huron Road Hospital, as treasurer, and Dr. Russell W. Hardy, Jr., of Cleveland Clinic, as secretary.

Dr. John R. Beljan, associate dean for medical education of the Medical School, University of California, has been named founding dean of the Wright State Univeristy School of Medicine and vice-provost of the University. He will assume his post July 1.

Dr. Heinz Pieper has been named chairman of the Department of Physiology in the Ohio State University College of Medicine by the University's Board of Trustees. He has been a member of the OSU physiology faculty for 17 years.

Dr. Harold S. Stricker, Marysville physician, has won recognition again as an amateur radio operator. He was first to receive the "Single Band Worked All Zones Award," in a contest sponsored by *CQ* radio magazine. The contest required an operator to contact 40 amateur radio zones throughout the world and receive confirmation. Starting his hobby at age 14, he holds a fifty-year certificate in the Quarter Century Club. His call letters are W8WZ.

Dr. Nino M. Camardese, of Norwalk, is the recipient of an award from the Freedoms Foundation at Valley Forge, Pa., for the third time. He has been given the "George Washington Honor Medal Award" for a booklet he has written entitled "Teenager." Publication is planned in the near future. He previously received awards in 1969 and 1972.

Dr. Robert E. Reiheld, Orrville, was named Citizen of the Year by the Orrville *Courier-Crescent,* having been selected for that honor by a citizens committee of seven members. He is chairman of the American Medical Association's Committee on Rural Health and has served on a number of OSMA committees. A past president of the Wayne County Medical Society, he was cited by the committee for participation in numerous community betterment projects.

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CANDEPTIN Vaginal Ointment Therapy Pack—two 75 gm. tubes
CANDEPTIN Vagelettes Therapy Pack—28 vaginal capsules
CANDEPTIN Vaginal Tablet Therapy Pack—28 vaginal tablets

Brief Summary

Description: CANDEPTIN (Candicidin) Vaginal Ointment contains a dispersion of Candicidin powder equivalent to 0.6 mg. per gm. or 0.06% Candicidin activity in U.S.P. petrolatum. 3 mg. of Candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain Candicidin powder equivalent to 3 mg. (0.3%) Candicidin activity dispersed in starch, lactose and magnesium stearate.

CANDEPTIN VAGELETTES Vaginal Capsules contain 3 mg. of Candicidin activity dispersed in 5 gm. U.S.P. petrolatum.

Action: CANDEPTIN Vaginal Ointment, Vaginal Tablets, and VAGELETTES Vaginal Capsules possess anti-monilial activity.

Indications: Vaginitis due to *Candida albicans* and other *Candida* species.

Contraindications: Contraindicated for patients known to be sensitive to any of its components. During pregnancy manual Tablet or VAGELETTES Capsule insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution: During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.

Adverse Reaction: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment, Vaginal Tablets or VAGELETTES Vaginal Capsules have been extremely rare.

Dosage: One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet or one VAGELETTES Vaginal Capsule is inserted high in the vagina twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Available Dosage Forms: CANDEPTIN Vaginal Ointment is supplied in a Patient Therapy Pack, containing two 75 gm. tubes with two applicators for the full course of treatment. CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil with inserter—enough for a full course of treatment. CANDEPTIN Vagelettes Vaginal Capsules are packaged in a Patient Therapy Pack, containing 28 CANDEPTIN Vagelettes Vaginal Capsules (2 boxes of 14), for the full course of treatment. Store under refrigeration to insure full potency.

Federal law prohibits dispensing without prescription.

References:

1. Melges, F. J.: Obstet. Gynecol. *24*:921, Dec. 1964. 2. Cameron, P. F.: Practitioner *202*:695, May 1969. 3. Olsen, J. R.: Journal-Lancet *85*: 287, July 1965. 4. Giorlando, S. W.: OB/GYN Digest *13*:32, Sept. 1971. 5. Decker, A.: Case Reports on file, Medical Department, Julius Schmid. 6. Friedel, H. J.: Md. State Med. J. *15*:36, Feb. 1966. 7. Roberts, C. L. and Sullivan, J. J.: Calif. Med. *103*:109, Aug. 1965. 8. Giorlando, S. W., Torres, J. F. and Muscillo, G.: Am. J. Obstet. Gynecol. *90*:370, Oct. 1, 1964. 9. Abruzzi, W. A.: Western Med. *5*:62, Feb. 1964.

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- Sensitivity and temporary irritation with CANDEPTIN (candicidin) Vaginal Ointment, Vaginal Tablets, and VAGELETTES Vaginal Capsules have been extremely rare.

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VAGELETTES™ Vaginal Capsules

Vaginal Ointment

Vaginal Tablets

OMI Highlights of 1973 Operations

OHIO MEDICAL INDEMNITY, the Ohio Doctors' Plan, continued to increase enrollment in 1973 in spite of the fact that the State of Ohio withdrew its approximately 100,000 members. The total enrollment was 3,419,866 at year's end, an increase of 1.84 percent over the previous year.

Here are highlights as presented to The Council of the Ohio State Medical Association.

Reorganization

One of the most significant events in 1973 was a complete corporate reorganization. Major emphasis was given to improving service and increasing the Plan's ability to prepare for the future. The number of corporate divisions was increased from three to five under the reorganization while the number of management levels was reduced, allowing more direct coordination and communication between all areas of activity.

Four new departments were added—Customer Service, Corporate Planning, Internal Auditing, and Peer and Utilization Review. As a result of the changes, OMI is able to respond more fully to service needs of both members and providers. Management can plan more productively for future opportunities and challenges, and can more closely direct progress toward corporate goals.

Claims Processing Innovations

Extensive efforts were made in 1973 to improve the effectiveness of claims processing by more fully utilizing the capabilities of OMI's sophisticated computer system. The first major step in this direction was expansion of the Batch Claims Payment System in October to all physician offices in the state. This system provides much greater information on the subscriber, his level of coverage, the payment and reasons for payment determinations or denials than was previously possible. Much of this new information is being furnished due to requests from physicians and their office staffs. Numerous compliments have been received on the Batch Claims System.

At the same time that the Batch System was introduced, work was initiated on an On-Line Claims Processing System. It eliminates much passing along of paperwork and certain previous steps in claims processing by providing examiners with access terminals for paying claims directly through the computer. Being implemented early in 1974, the On-Line System will reduce overall claims processing time, increase accuracy of claims payments and allow more immediate response to members' inquiries.

Financial

Total earned subscription income during 1973 was $117,505,000, compared to $103,250,000 in 1972. Incurred claims expense totaled $99,350,000, compared to $91,552,000 in 1972. Operating expenses, while increasing from $11,725,000 to $13,196,000, dropped from 11.35 percent of total subscription income in 1972 to 11.23 percent in 1973.

Total income transferred to general reserve increased from $2,253,000 in 1972 to $10,356,000 in 1973. This represents the equivalent of 3.72 months of claims and expenses, while 1972 reserves accounted for 2.85 months.

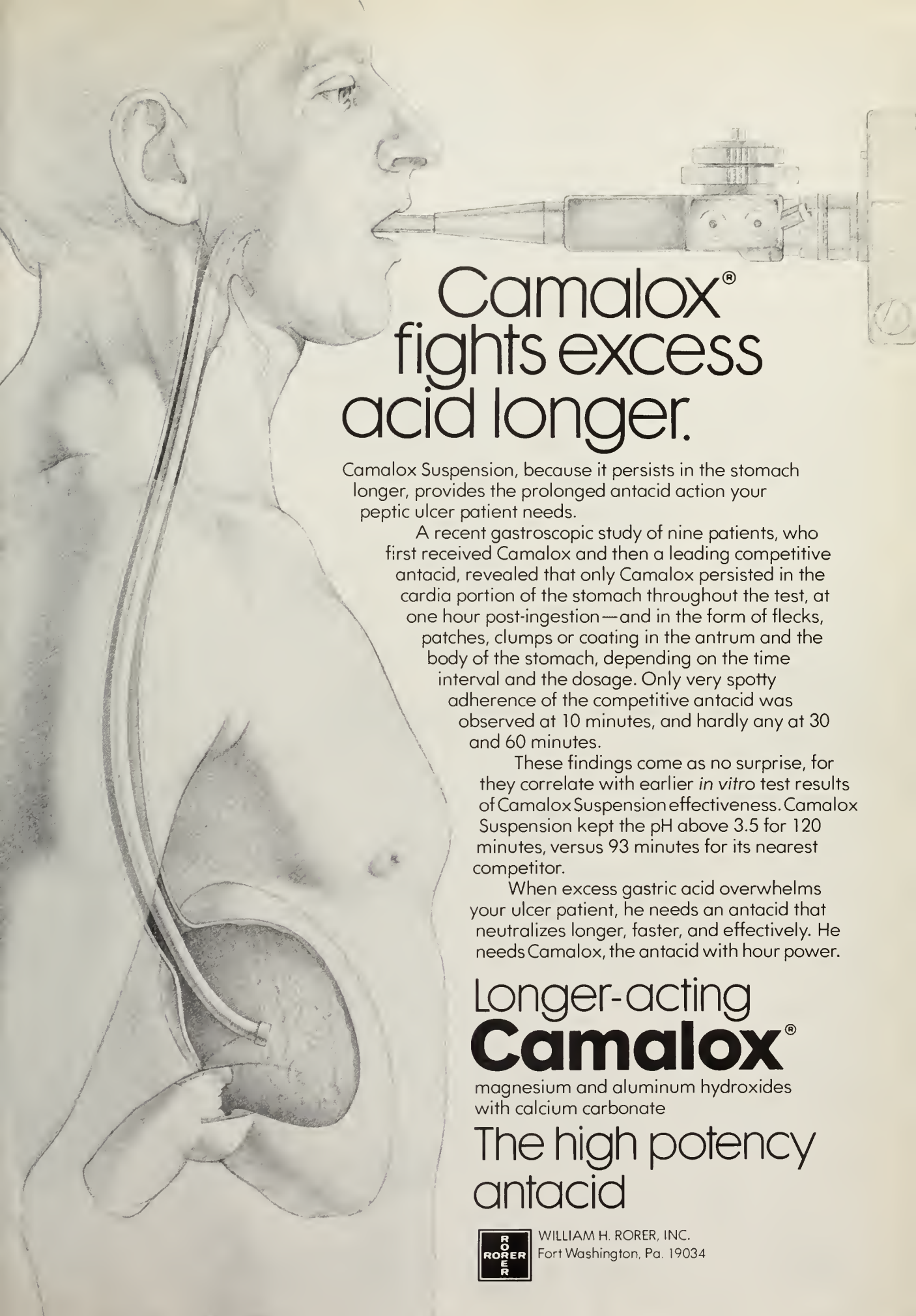
Enrollment

Total enrollment at year-end was 3,419,866 members, an increase of 1.84 percent over the previous year. While not especially large, the increase assumes greater significance when it is realized that this was during the same period when the Ohio Blue Cross & Blue Shield Plans lost the State of Ohio account, totaling approximately 100,000 members.

The year 1973 saw continued growth of the UCR (usual, customary and reasonable) contract, now covering over 60 percent of all group subscribers. The indemnity contracts continued to decrease, with the "Standard" Contract covering only 2.8 percent of group membership and the "Preferred" and "Major" Contracts covering 17.2 percent and 14.8 percent respectively. National Accounts and Special Accounts make up the remainder of the group business. Direct Pay enrollment grew 2.1 percent in 1973, at year end totaling 877,326 members.

One of the most significant Enrollment achievements in 1973 was the selection of OMI by General Motors as the carrier for its new Dental benefit package. This contract—which goes into effect October 1, 1974—will expand dental coverage to some 200,000 GM hourly employees

(Continued on Page 308)



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*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The aspect of privacy.
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Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclital antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute ganorrheal urethritis and proctitis in the male and acute gonarrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9%* w/v. Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
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† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

and their families in Ohio. Additionally, the GM selection will greatly enhance OMI's marketing potential for dental coverage with other groups throughout the state.

Alternate Delivery Systems

During 1973 OMI became involved, on an experimental basis, with four programs in the state which could classify as Alternative Delivery Systems. Both financial and technical support have been provided to the Medical Advances Institute. Staff involvement increased with both the Western Ohio Foundation for Medical Care, located in Dayton, and the Midwest Foundation for Medical Care, located in Cincinnati. Plans were developed to initiate study programs with these Foundations in the area of Utilization and Peer Review. Plans were finalized for cooperation with the Good Samaritan Hospital-Health Maintenance Program, an HMO (Health Maintenance Organization) located in Cincinnati. These plans include a limited role in underwriting out-of-area care for HMO members and providing some claims processing services on a no-risk basis.

As plans made during 1973 come to fruition in 1974, the degree of corporate involvement in these alternative delivery programs will expand in volume and possibly in scope.

Cleveland Clinic to Share in CHD Long-Range Study

The Cleveland Clinic is one of 20 centers throughout the nation taking part in the "Multiple Risk Factor Intervention Trial" sponsored by the National Heart and Lung Institute. The clinic will enroll some 600 volunteers toward the total of 12,000 needed for the study—men age 35-57 who are at above average CHD risk.

Some $11 million per year for seven years has been estimated as the nationwide cost of the project. Dr. Harriet P. Dustan, vice-chairman of the Research Division at the Cleveland Clinic will head the local project.





Spasm reactor?

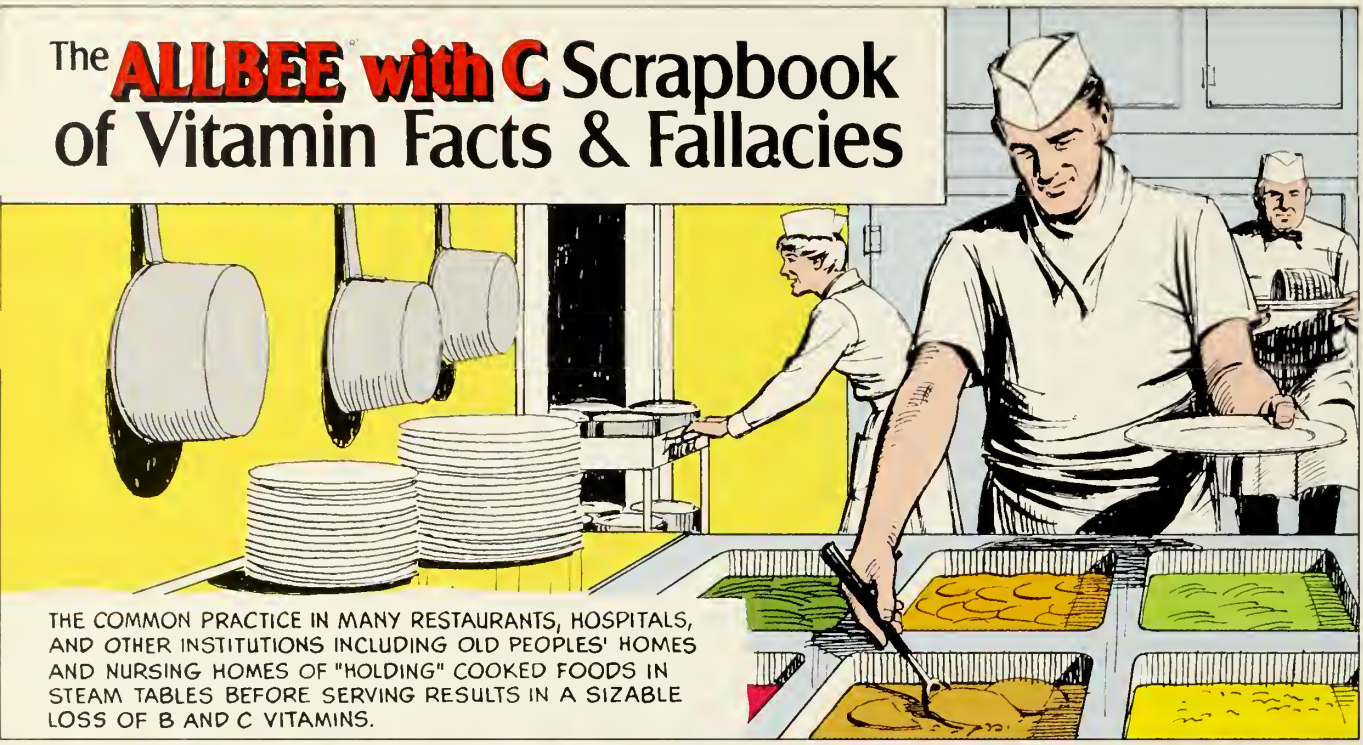
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Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

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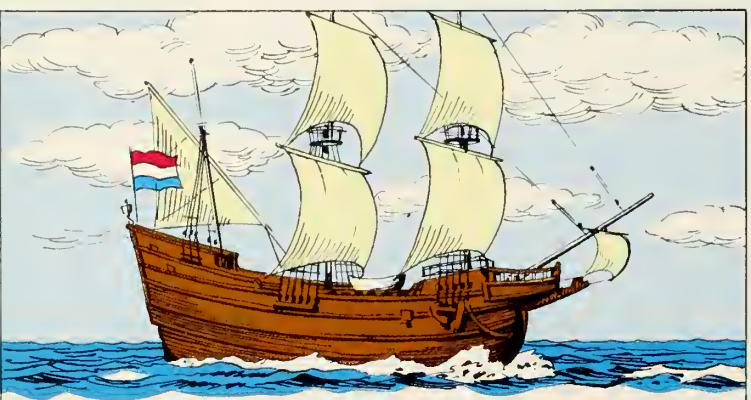
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Obituaries

Erastus Randall Alexander, M.D., Ormond Beach, Fla.; formerly of Rittman and Apple Creek; Western Reserve University School of Medicine, 1909; aged 92; died March 11; member of OSMA and AMA.

David Brown, M.D., Bellaire; Ohio State University College of Medicine, 1935; aged 66; died January 27; member of OSMA and former member of AMA.

Russell Paul Dreyer, M.D., Cleveland; Ohio State University College of Medicine, 1943; aged 57; died March 19; member of OSMA and AMA.

Virgil Chiles Hayes, M.D., Newark, N.J., formerly of Youngstown; Howard University College of Medicine, 1963; aged 49; died March 25.

Hans Paulson Lee, M.D., Toledo; University of Iowa College of Medicine, 1921; aged 86; died March 4; member of OSMA and AMA.

Emmet Carl Lentz, M.D., Ashland; Ohio State University College of Medicine, 1931; aged 68; died February 25; member of OSMA and AMA.

Roswell Lowry, M.D., Cleveland; New York Medical College; aged 71; died March 10; member of OSMA and AMA.

Joseph Russell McWhirt, M.D., Dayton; George Washington University School of Medicine, 1951; aged 54; died March 10; member of OSMA and AMA.

Clarence John Schirack, M.D., Canton; Eclectic Medical College, Cincinnati, 1915; aged 81; died January 21; member of OSMA and AMA.

Earl W. Sutherland, Jr., Miami, Fla.; formerly of Cleveland; Washington University School of Medicine, 1942; aged 58; died March 10.

John Finley Weber, M.D., Marietta; Ohio State University College of Medicine, 1910; aged 93; died March 19; member of OSMA and AMA.

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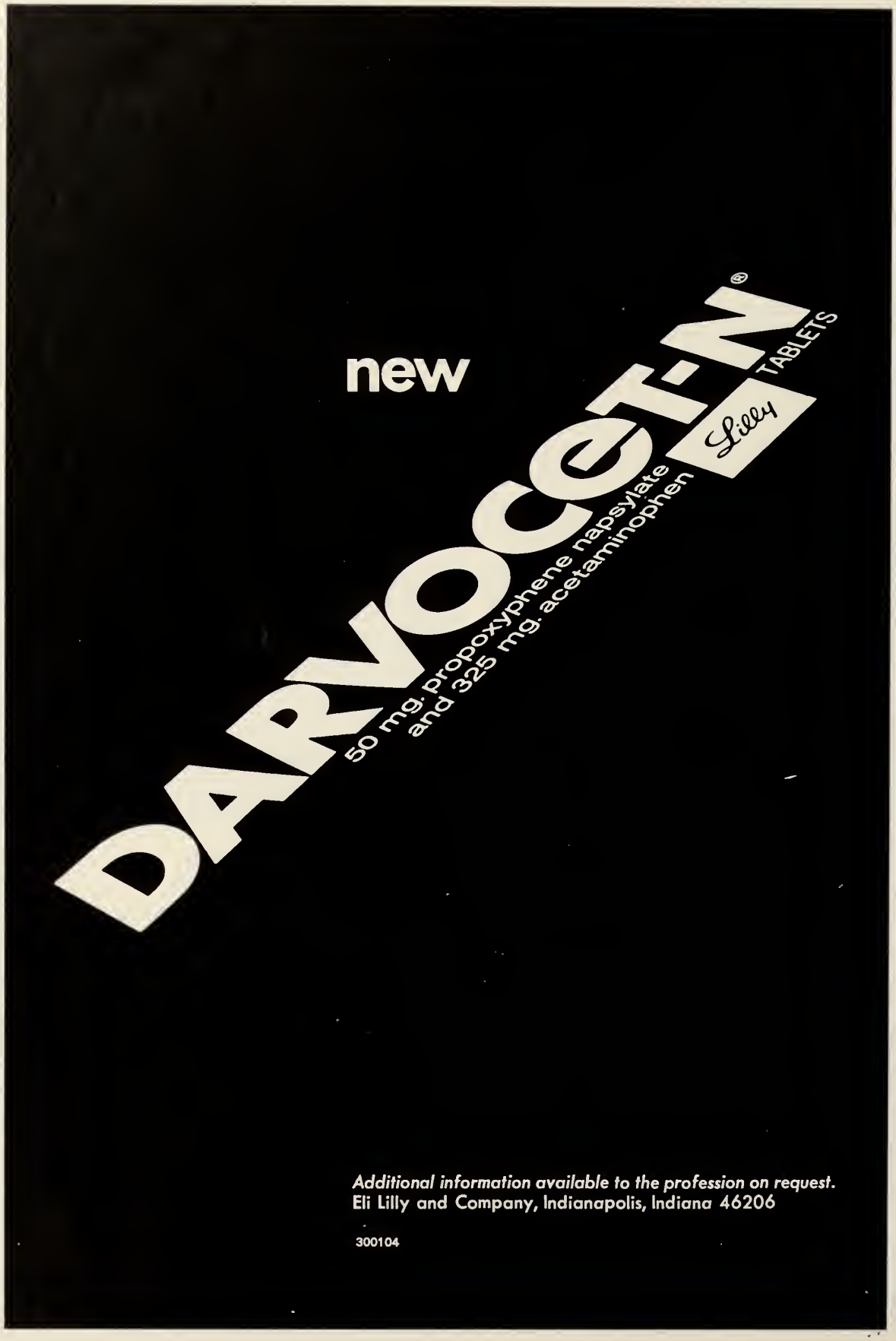
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Diagnostic Peritoneal Lavage in Acute Abdominal Problems

William R. Schiller, M.D.
John W. LaVoo, M.D.

ACCURATE DIAGNOSIS of acute abdominal diseases is often difficult, especially in cases of trauma victims with multiple injuries, in obtunded patients with abnormal abdominal findings, and in those patients with obscure abdominal illnesses. Attempts to improve diagnostic accuracy by visceral angiography, peritoneoscopy, and four-quadrant peritoneal tap have met with varying degrees of acceptance and enthusiasm. Although positive results from these procedures are helpful, the rate of false-negative results is high. The magnitude of the problem is illustrated by the report of Brittain in 1963; thirty-three false-negative, four-quadrant peritoneal taps were obtained from a series of 51 patients suffering from blunt liver trauma.[1] Nevertheless, accurate diagnostic technics are necessary. Williams and Zollinger reviewed 200 patients with blunt abdominal trauma and reported that over 80 percent of deaths were due to hemorrhage and, in half of these, there was a significant delay in diagnosis and treatment.[2]

Four-quadrant tap often fails to produce a representative sample of peritoneal fluid, the primary reason for false-negative results. Free blood tends to pool in dependent areas, namely, the pelvis, lumbar gutters, and beneath the diaphragms. Remaining fluid is widely distributed resulting in only a thin layer of fluid on the peritoneal contents. Laboratory studies by Giacobine and Siler[3] confirm the preceding facts and provide insight into the problem of obtaining a positive tap. They injected 25 ml of blood containing I^{131} into the peritoneal cavity of dogs. Within three minutes, there was generalized distribution of the blood, probably due to surface tension, peristalsis, and pumping action of the diaphragms. In addition, they demonstrated a linear relationship between positive tap rate and the volume of fluid in the peritoneal cavity. In dogs with blood injected intraperitoneally in amounts corresponding to 50 ml in a 75-kg man, none of 100 taps was positive. Even when the volume was raised to 500 ml, there was only a 78 percent rate of positive taps. It was impossible to detect any amount less than the equivalent of 200 milliliters.

The volume necessary for a meaningful peritoneal fluid sample can be produced by the simple procedure of infusing a liter of electrolyte solution such as Ringer's lactate into the peritoneal cavity. Allowing time for adequate mixing and then withdrawing the infused fluid results in a more representative sample and a greater degree of accuracy. Root and associates[4] reported 100 percent accuracy with this technic in 28 patients with a variety of lesions. This report describes our experience with four-quadrant taps and diagnostic peritoneal lavage over the past three years.

Material and Methods

The records of patients who underwent four-quadrant peritoneal tap at the Medical College of Ohio Hospital during the period from July 1970 to July 1971 were reviewed retrospectively. Following radiographic evaluation, four-quadrant taps were performed using local anesthesia. A #18 needle with attached syringe was gently inserted through the subcutaneous anesthetic wheal into the peritoneal cavity in each of four quadrants. Recovery of nonclotting blood was the primary criterion for evaluation of four-quadrant taps.

Diagnostic peritoneal lavage was prospectively evaluated over the past two years from 1971 to 1973. The technic advocated by Veith and coworkers[5] was used. Prior to the procedure, abdominal plain x-ray studies were completed so that introduced air would not be a source of confusion. The urinary bladder of the patient was emptied prior to performing the procedure. With the patient in a supine position, the abdomen was prepared and sterile drapes were applied. When the

Dr. Schiller is Attending Surgeon, Medical College of Ohio Hospital, and Assistant Professor of Surgery, Medical College of Ohio at Toledo.

Dr. LaVoo is a Major in the U.S. Air Force Medical Corp, Nellis Air Force Base, Nevada.

Submitted September 14, 1973.

Table 1. Results of Four-Quadrant Peritoneal Tap

Total patients		13
Positive result		8
True positive		7
Negative result		5
True negative		2
Overall accuracy	69%	
False positives	8%	
False negatives	23%	

abdomen was free of scars, a one-to-two-centimeter incision was made in the midline 4 centimeters below the umbilicus, after 1% lidocaine infiltration anesthesia. If there were abdominal midline scars, the incision was placed at the lateral edge of one of the rectus muscles. The anterior rectus fascia was incised, and the edges were grasped with forceps and pulled anteriorly. A peritoneal dialysis catheter was inserted with a gentle twisting motion. Upon entering the peritoneal cavity, the trocar was removed, and the catheter was advanced until all perforations were within the peritoneal cavity. The catheter was aspirated and if no fluid was recovered, 1000 ml of saline or Ringer's lactate solution was instilled. The patient was turned from side to side twice unless contraindicated, and the fluid was then allowed to drain into a collection bottle by gravity. If fluid was recovered on initial aspiration, it was sent for analysis and the decision whether or not to lavage was left to the judgment of the physician.

Approximate normal values for the recovered peritoneal fluid reported by Veith and co-workers have been used in this study.[5] They reported a pH range of 5 to 8 and protein content of 0 to 100 mg per 100 ml. Negative lavage fluid specimens were clear in 25 percent, cloudy in 25 percent, and pink in 50 percent of cases. Gram stain showed no organisms normally and fluid amylase levels of 120 Somogyi units or less were considered negative. Cell counts on recovered fluid indicated normal values for white cells ranged from 0 to 1200 cells per cu mm and 0 to 100,000 cells per cu mm for erythrocytes.

We also used their indications for this procedure. These include: (1) diagnostic problems in high risk patients; (2) obtunded or uncommunicative patients with signs or symptoms suggesting the possibility of acute abdominal disease; (3) patients with a history of recent abdominal trauma, especially those with multiple injuries; and (4) patients with suspected pancreatitis in whom nonoperative therapy was planned. Other possible indications which we have not yet encountered during the study include drug addicts with acute abdominal disease and suspected nonsurgical, acute abdominal disease.

Table 2. Results of Present Series in Diagnostic Peritoneal Lavage

Total patients		40
Positive results		21
True positive		19
Negative result		19
True negative		18
Overall accuracy	92.5%	
False positives	5.0%	
False negatives	2.5%	

Relative contraindications which we have observed are: (1) pregnancy; (2) presence of multiple scars and distended bowel; and (3) presence of a clear-cut diagnosis by standard means. This examination is of little use in the differential diagnosis of an obvious intra-abdominal inflammatory process.

Results

I. *Four-quadrant tap.* Our experience with blunt abdominal trauma during the year 1970-1971 at the Medical College Hospital demonstrated the inaccuracies of four-quadrant peritoneal tap (Table 1). Thirteen patients were evaluated, eight of whom had positive taps. Seven of these were proven positive at abdominal exploration. Of the five patients who had negative taps, three proved to have serious intra-abdominal injuries. The relative accuracy of positive taps, along with the high rate of false negatives, was in agreement with previous reports.[1,6] The overall accuracy in this small series was only 69 percent.

II. *Diagnostic peritoneal lavage.* During the period from 1971 to 1973, diagnostic peritoneal lavage was performed in 40 patients (Table 2).

Nineteen of these yielded negative results which included one false negative. This case involved a 19-year-old male, injured in a motorcycle accident. On admission, he was dyspneic, cyanotic, and restless with a tachycardia of 120 beats per minute and a systolic blood pressure of 90 mm Hg. Examination also revealed a left ulnar fracture, bilateral pneumothorax, severe contusion to both lungs, and pneumopericardium. In addition, there was an abrasion in the left upper quadrant of the abdomen and a well-healed left paramedian abdominal scar from a previous post-traumatic splenectomy. His abdomen was soft, non-tender and bowel sounds were present.

Treatment included bilateral tube thoracostomy, pericardiocentesis, and a diagnostic peritoneal lavage which was reported as negative. The next day the patient's abdomen was distended and his serum amylase was 1420 Somogyi units. He was suspected of having a pancreatic injury; however, because of the severe pulmonary problem, only supportive treatment was given. The next day his general condition improved, and it appeared that he would recover. Approximately ten days after injury, he developed fever, abdominal pain, and recurrent elevated serum amylase. A barium swallow revealed anterior displacement of the stomach.

External drainage of a pancreatic abscess was performed and the patient subsequently made an uneventful recovery.

Twenty-one of 40 peritoneal lavages yielded positive results. This included two patients in whom no intra-abdominal disease was evident; neither of the two false-positive results in this series caused difficulty in management. One was caused by temporary failure of the surgeon to control bleeding at the point of the catheter insertion and the patient made an uneventful recovery. The second false-positive consisted of a protein content of 236 mg per 100 ml in an otherwise normal tap in a man suffering from an intrathoracic gunshot wound. At thoracotomy, there was a large lower esophageal perforation and mediastinal hematoma with no evidence of intra-abdominal injury.

The overall accuracy rate in this series of 40 patients was 92.5 percent. No complications were encountered as a result of this procedure. There were 19 true positive results: of these, 14 were related to blunt abdominal trauma (Table 3). Splenic rupture, found in 10 patients, was the most

Table 3. Pathology from Positive Lavage

Ruptured spleen	10
Mesenteric tear	2
Hepatic laceration	1
Omental tear	1
Hemorrhagic pancreatitis	1
Perforated ulcer	1
Ruptured ectopic pregnancy	1
Cholecystitis	1
Gangrenous ileum	1
Total	19

common injury. Three had either omental or mesenteric tears and one had an hepatic laceration. All but one had detectable hemoperitoneum; the exception had a mesenteric tear associated with ileal perforation. The lavage fluid contained 260 mg per 100 ml protein and 710 leukocytes per cubic millimeter. This was interpreted as a positive result, and prompt operative repair was performed. Five nontraumatic lesions were encountered, including single cases of acute hemorrhagic pancreatitis, perforated duodenal ulcer, ruptured ectopic pregnancy, acute cholecystitis, and gangrenous ileum secondary to strangulation obstruction. Hemoperitoneum was detected only in the patient with ruptured ectopic pregnancy, while the remaining four patients had elevated protein and amylase levels along with intraperitoneal leukocytes

Discussion

In our experience, traumatic splenic rupture was the most commonly encountered lesion. This is in agreement with other reports.[7,8]

Gumbert and associates[6] compared the accuracy of four-quadrant tap with that of diagnostic peritoneal lavage and reported only one false-positive lavage in a series of 53 examinations, giving an overall accuracy rate of 97 percent. However, there were four false-negatives in 11 four-quadrant taps, for an accuracy rate of only 64 percent. Our accuracy rates of 93 percent for lavage and 69 percent for taps are similar to Gumbert's results and demonstrate the superiority of diagnostic peritoneal lavage. Other reports of accuracy rates using diagnostic peritoneal lavage range from 93 to 100 percent.[4-7,9,10]

Both false-positive and negative rates have been reported in the range of 3 percent or less. Diagnostic lavage is not well suited to detection of retroperitoneal injuries, a situation which contributes heavily to false-negative results. The false negative in the present series is a result of this situation.

False positives are related to the overall high sensitivity of this test. Faulty technique is a frequent source for this type of problem. In addition, some trivial intra-abdominal injuries not requiring operative intervention will be detected by this method. Quantitation of recovered lavage fluid contents is helpful in avoiding this error since mild contamination is the rule with minimal injuries, such as nonbleeding contusions or lacerations of omentum or mesentery.

While we have had no complications in our series, others have noted a complication rate of 1 to 5 percent.[5,7-10] Complications have usually occurred early in each series and most were the result of improper use of the trocar. Caffee and Benfield[8] have compiled a list of guidelines for proper performance of the procedure. They include incision of skin and subcutaneous tissue to the peritoneum; gentle insertion of the catheter, immediately removing the trocar and insertion of the catheter away from the midline; tensing of the abdominal wall musculature to facilitate insertion through the peritoneum; and avoidance of previous incisions and masses.

Use of standard guidelines for interpretation of the lavage results will aid in avoiding diagnostic errors. Although we have used cell counts, other suitable standards are available. For instance, Olsen and associates[7] have used a method of visual evaluation in which color and opacity of the lavage fluid are the criteria for categorization of results as strongly positive (red, opaque), weakly positive (clear to pink, nonopaque), or negative. They have reported that red opaque lavage fluid contains at least 25 ml of blood per liter and may be interpreted as a positive lavage with an accuracy rate of 98 percent. They also have concluded that 100,000 red blood cells per cu mm is roughly equivalent to 22 ml whole blood per liter, providing a close correlation of the two methods. On the other hand, fluid which is pink and clear contains less than 25 ml blood per liter and is interpreted as

weakly positive. Approximately 30 percent of these cases represent either no injury or a trivial injury. In this group they advocate use of visceral angiography along with integration of clinical findings as a means of further evaluation. Absolutely clear fluid indicated a negative result with reliability levels similar to those of the strongly positive group. Lastly, there is a difference of opinion regarding the number of leukocytes in lavage fluid which represent an accurate diagnostic criterion. Veith[5] requires 1200 white blood cells or more per cu mm, while Perry[9] has stated that levels over 500 white blood cells per cu mm are indicative of intra-abdominal injury. This problem should be kept in mind when evaluating leukocyte counts of lavage fluid.

Summary

Experience with diagnostic peritoneal lavage at the Medical College of Ohio Hospital from 1971 to 1973 involved a series of 40 patients. Overall accuracy was 92.5 percent, representing 37 of 40 patients; one patient had a false-negative and two had false-positive results. Reasons for these erroneous results were described. No complications were encountered as a consequence of this diagnostic maneuver.

Thirteen patients had four-quadrant taps in the period from July 1970 to July 1971. Overall accuracy in this small series was 69 percent, with one false-positive and three false-negatives reported. In this rather limited number of patients, diagnostic lavage appeared to be more accurate than peritoneal tap in the evaluation of acute abdominal problems.

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Evaluation of McKeever Tibial Plateau Arthroplasty of the Rheumatoid Knee

Richard A. Freiberg, M.D.
Paul W. Welch, M.D.

RHEUMATOID ARTHRITIS is a common disease with the well-known capacity to cause severe joint destruction. The knee is one of the joints most commonly involved by this disease, and, when there is sufficient involvement to cause marked disability, joint reconstruction becomes appropriate. In the past, arthroplasty has been attempted by interposition of a variety of materials such as fascia lata,[1,2] chromocyzed pig bladder, nylon,[3] and acrylic. None of these has met with much success. In the past two decades, however, metallic implants have proved effective. Various authors have reported good results with tibial plateau implants [4-11] and femoral condylar prostheses.[12] More recently, total-joint replacement arthroplasty has become available.[13-17]

While total hip replacement in rheumatoid arthritis has enjoyed reliable success, many do not have the same degree of confidence in total knee replacement. With this in mind, we have elected to evaluate our results over the past 3½ years with McKeever tibial implant arthroplasty (Figs. 1 and 2). We hope that this study will aid in deciding which patients we should offer implant arthroplasty and which patients total knee replacement arthroplasty.

Materials and Methods

Twenty-eight patients had McKeever arthroplasty of the knee performed by the senior author over the past 3½ years. Of this group, 24 patients had proven rheumatoid arthritis according to the criteria established by the American Rheumatism Association; four had osteoarthritis. Three of the

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24 rheumatoid patients were lost to follow-up, leaving 21 rheumatoid patients available for review. The junior author, who had had no previous contact with the patients, performed this final evaluation. There were 14 women and seven men. Five patients had bilateral surgery, resulting in a total of 26 knees available for evaluation. Seventeen of the 26 knees had both a medial and a lateral prosthesis inserted; nine knees had a single prosthesis, medial or lateral. Ages ranged from 33 to 70 years, with a mean age of 57 years. Follow-up ranged from 9 to 42 months postoperatively. The mean follow-up was 21 months.

All patients had anatomical stage III rheumatoid arthritis according to the criteria of the American Rheumatism Association. Patients were evaluated primarily according to Potter's numerical grading system,[9] which takes into account many subjective and objective parameters. The final score is determined by a total demerit system with pain being assigned the highest number of demerits.

Results

According to the Potter grading system, the overall results were excellent (two), good (16), fair (seven), poor (two), for a 69 percent good and excellent rate.

The American Rheumatism Association Functional Classification was also used. Note the shift from class III and IV patients into class II postoperatively (Table 1).

Patient satisfaction was graded. Fourteen felt they were greatly improved; five, moderately improved; one, slightly improved; one, no improve-



FIG. 1. Preoperative roentgen showing changes characteristic of moderately advanced rheumatoid arthritis.

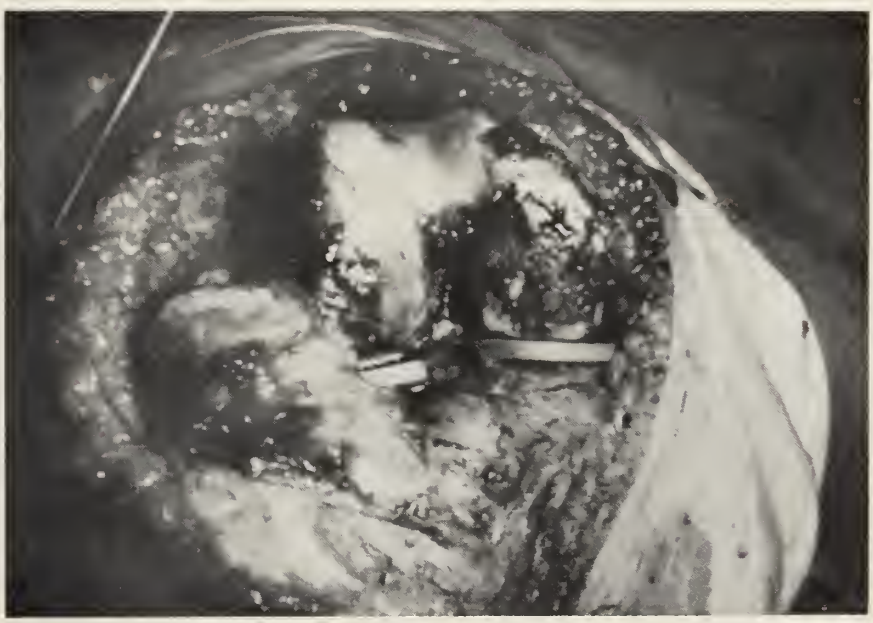


FIG. 2. Medial and lateral McKeever prostheses are in place.

ment. All would have the surgery performed again except the one who felt he had no improvement.

Marked relief of pain occurred in all patients. Two had complete relief; 16 had discomfort after extensive physical activity. Three persisted in needing analgesics stronger than salicylates after surgery but claimed this was because of symptoms in joints other than their knees.

Preoperative varus and valgus deformity was a problem in a number of these patients, often as much as 20°. In every instance, a satisfactory correction of angular deformity was accomplished. Flexion contracture was not corrected by the McKeever knee arthroplasty, but only one patient had a significant functional problem from residual flexion contracture.

No patient has yet had a recurrence of synovitis in his knee, despite severe preoperative synovitis in many instances.

Postoperative range of motion varied from 40° to 118°, with a mean of 81°.

Figure 3 compares postoperative range of motion with postoperative flexion contracture. It is evident that in most knees we attained an adequate range of motion in a functional range for ambulation, which is probably more important than actual degrees of motion attained.

Complications

Complications were few in number. A superficial infection occurred in one patient and was treated successfully with drainage and antibiotics. Wound hematoma in two patients was treated by aspiration and cast without sequelae. No thromboembolic phenomena were encountered. There were no deaths.

Discussion

The bias of patient loyalty renders evaluation of a series of patients such as this difficult at best. An impartial observer was used in an attempt to minimize this. Our results compare favorably with the larger studies of tibial plateau implant arthroplasty in the literature (Table 2).

It is evident from review of the literature and our series that this is an entirely satisfactory operative procedure for many severely involved rheumatoid knees. Knees with grinding crepitus, pain, and genu valgus or varus deformity respond well after this operation. The presence or absence of active synovitis did not appear to affect the end result. However, a flexion deformity of more than 15° should be considered a contraindication to McKeever arthroplasty unless osteotomy of the femur or posterior capsulotomy is planned as a second procedure. Interpositional arthroplasty will gain good

Table 1. Results According to American Rheumatism Association Classification

Stage	Preoperative	Postoperative
II	5	13
III	12	7
IV	4	1

Table 2. Overall Good-Excellent Results According to Potter Grading System

Study	%
This series	69
MacIntosh	69
Kay	85
Potter	56
Dewar	73
Murray	80

results if good pre- and postoperative care is possible, namely, vigorous exercise, manipulation under anesthesia when necessary, and limited weight bearing for three months. In older patients or patients who are more seriously involved with generalized destructive disease, we no longer perform McKeever arthroplasties but select total-knee-replacement arthroplasty. Severe osseous involvement, particularly of the femoral condyles, should usually be considered an indication for total knee replacement.

Summary

Arthroplasty of the rheumatoid knee with McKeever tibial plateau prostheses has been evaluated. Twenty-one patients with "classical" rheumatoid arthritis, according to the American Rheumatism Association criteria, had 26 McKeever arthroplasties performed by the senior author.

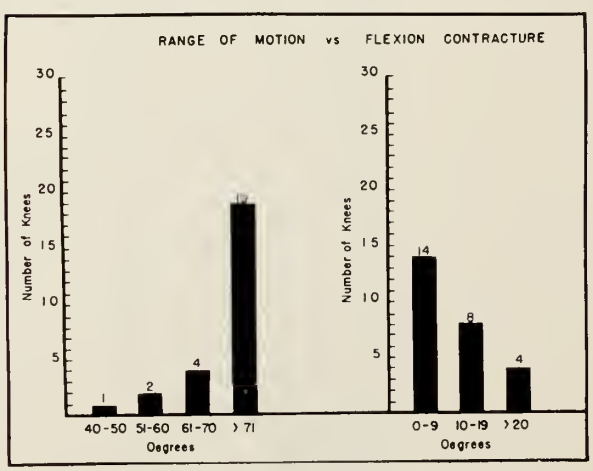


Fig. 3. Comparison of postoperative range of motion with postoperative flexion contracture.

Each patient was evaluated postoperatively by the junior author. Follow-up ranged from 9 to 42 months. Sixty-nine percent of the patients had good or excellent results. Marked pain relief was accomplished in all patients and none had a recurrence of synovitis. Moderate varus and valgus deformities were readily corrected. The mean range of postoperative motion was 81°.

It was the authors' conclusion that good results can be expected with McKeever knee arthroplasty in properly selected patients.

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Dr. Welch, Canton, is an orthopedic surgeon and a member of the Attending Staff, Aultman Hospital.

Submitted November 19, 1973.

Lead Encephalopathy

Report of a Case Associated With Industrial Exposure

Miguel A. Pedraza, M.D.
Frank Anzinger, M.D.

AS IS WELL KNOWN, lead intoxication in adults may be encountered among employees of a variety of industries. The most frequent portal of entry of this element is said to be the respiratory tract, but it is possible to absorb enough tetra-ethyl lead through the skin to produce toxic manifestations.

Since 1955, several investigators have reported the occurrence of lead intoxication from ingestion of contaminated moonshine liquor.[1-4] In a recent series reported at the University of Alabama, 23 patients with encephalopathy and proved lead intoxication were described.[5] Thirty additional patients were reviewed from the English language literature. The same authors could find only one recorded case of lead encephalopathy in the United States since 1960, in which the source was industrial exposure.[6]

Because of the scarcity of documented cases of lead encephalopathy in adults from an industrial source, we wish to add the following report to the existing literature.

Case Report

A 44-year-old white man was first seen in the mental health center of Mercy Hospital on June 6, 1973. His diagnosis at that time was schizophrenia, paranoid type, and anemia.

The patient's wife gave the following history: The patient was extremely irritable, he fought and argued with the family constantly and was profane. She stated that he was very forgetful and lacked coordination. For the three weeks prior to admission, the patient was having insomnia and

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Dr. Anzinger is a member of the Attending Staff, Mercy Hospital, Springfield.

Submitted September 13, 1973.

was depressed. He was lethargic and had periods of inappropriate laughter. He often moved his lips as if he were talking to someone. He also was paranoid concerning his wife.

One day he was found at the shop kneeling on the floor with his arms raised above his head, and apparently was talking to himself. He stated that his mother had put him in this position. He also would wander away from his job at the shop. For these reasons, he was admitted to the mental health center.

For the last seven years he had been employed by a brass company in Springfield, Ohio, as a metal cutter; we were told that the lead content in the brass was ten percent. The material from the cuttings would cover his body by the end of a working day.

The past history was essentially negative except that he admitted to having had venereal disease in Japan for which he had received penicillin. His VDRL test is nonreactive at this time.

Physical Examination

The patient appeared to be confused. He had carious teeth associated with severe gingivitis, and the base of them showed a zone of gray discoloration, but no lead line was detected. The tongue, throat, tonsils, and ears were normal. The blood pressure was 115/70 mm Hg; heart rate and pulse 100 beats per minute and normal. The liver and spleen were not enlarged. There was no abdominal rigidity or tenderness, no costovertebral pain or abdominal murmurs. The fingers suggested a slight clubbing. There was a marked green pigmentation beneath all his nails which was later scraped and found to contain lead (4.42 parts per million). His reflexes were normal. Neurologic examination disclosed lethargy and disorientation. Result of motor and sensory examination was normal. Peripheral pulsations were normal.

Laboratory data included: Hemoglobin 8.9 gm per 100 ml; hematocrit reading 28 percent; red blood cell count (RBC) 3,410,000 per cu mm. The white blood cell count (WBC) was 5,100 per cu mm, with 58 neutrophils, 34 lymphocytes, 1 stab, 3 monocytes, and 4 eosinophils. Because of the marked basophilic stippling of the peripheral blood, heavy metal poisoning was suspected (Fig. 1). The bone marrow showed marked erythroid hyperplasia with basophilic stippling (Fig. 2). Direct and indirect Coombs' tests were negative. Reticulocyte count was 82 percent. Blood lead was 192 mcg per 100 ml (normal 60 mcg per 100 ml). Urine lead was 0.11 mcg per ml (normal 0.01 to 0.07 mcg per ml). Delta-amino levulinic acid was 3.8 mg per 100 ml (normal 0.00 to 0.54 mg per 100 ml). Urinary coproporphyrin excretion was increased and porphobilinogen was present in normal amount. Results of the following tests were

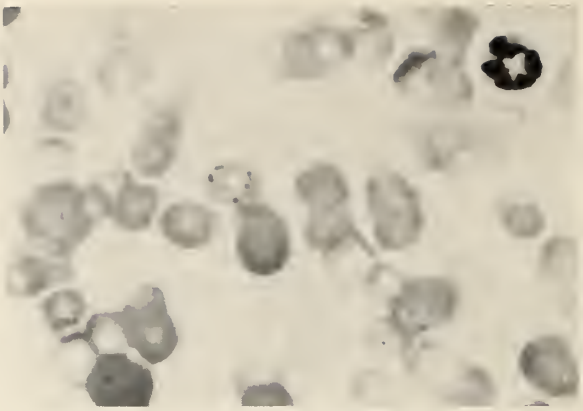


Fig. 1. Intense basophilic stippling shown in peripheral blood.

normal or negative: blood urea nitrogen (BUN), serum creatinine, serum bilirubin, uric acid, lactic dehydrogenase (LDH), glucose, and cholesterol. Creatinine clearance was 45 cc per minute. A lumbar puncture showed a white blood count of 6, red cells 4; total protein 58 mg. VDRL and FTA-ABS tests were nonreactive. Glucose was 28. (Blood glucose was 94 mg per 100 ml.) On June 26, 1973, five days of treatment was initiated with one gram (5 cc) calcium disodium edathamil (EDTA) dissolved in 250 cc of 5% sterile dextrose solution given twice a day. The second five-day series of this treatment was initiated on July 9, 1973.

The patient's hospital course after treatment was one of marked improvement of sensorium and neurologic symptoms. At the end of the second series of EDTA, his blood lead had fallen to 56 mcg per 100 ml. A repeat hemoglobin after discharge was 13.6 gm per 100 ml with a hematocrit reading of 43.0 percent.

We have been informed that the patient is now at home. He gets along well with his family.

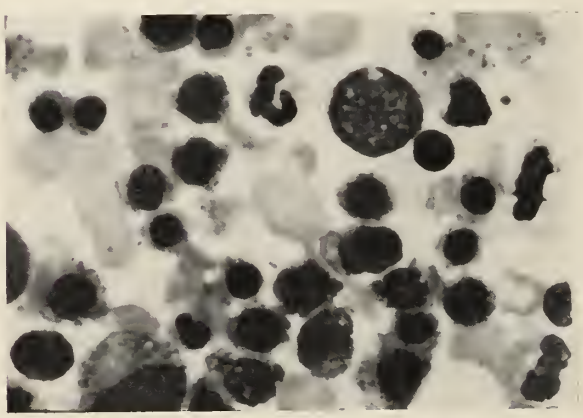


Fig. 2. Normoblastic hyperplasia and intense basophilic stippling shown in bone marrow.

The patient, his family, and his employer were made aware of the hazards of future exposure.

Discussion

The clinical picture of lead encephalopathy may be seen in a variety of manifestations ranging from psychosis, mental impairment, dizziness, headache, vomiting, ataxia and insomnia to somnolence, localized neurologic impairment, coma, convulsions, and eventually death.[3,4] Suggested criteria for acceptance of diagnosis of lead encephalopathy have been described by Whitfield et al.[5] These include:

1. Documented presence of a diffuse encephalopathy without focal signs.
2. Diagnosis of lead toxicity:
   (A) Clinical findings of lead poisoning.
   (B) Increased urine and blood levels.
3. Clinical diminution of the encephalopathy with CaEDTA therapy. (Diminution not reasonably attributed to other treatment used.)
4. Exclusion of other causes of encephalopathy.

The same author summarized as the most frequent findings in adults with lead encephalopathy the following: seizures (70 percent of the cases); papilledema (15 percent); lead line (43 percent); anemia (100 percent); elevation of cerebrospinal fluid protein (65 percent); WBC (35 percent); elevated urinary coproporphyrins (82 percent); urine and blood toxic levels (100 percent); mortality (13 percent).

Bucy and Buchanan pointed out that lead encephalopathy may be mistaken for a brain tumor in children[7] and Hess, in 1961, reported a case of lead encephalopathy in a 40-year-old Negro in whom symptoms were very suggestive of a subdural hematoma. Only when the arteriography failed to reveal any intracranial lesion, it became necessary to search for other etiologies and, finally, a diagnosis of lead encephalopathy was made after a history of possible lead exposure was obtained and lead intoxication was demonstrated.[6]

He has suggested that lead levels in cerebrospinal fluid are not helpful in the diagnosis of lead encephalopathy in adults. Lead poisoning, despite great experience with the disease, still remains very much our concern. The diagnosis of lead encephalopathy is difficult in patients whose source of lead is "moonshine" and in whom one or more of the complications of alcoholism are present concomitantly. Although industrial prophylaxis has been fairly effective in preventing dangerous exposure to lead, the present report suggests that lead encephalopathy due to industrial exposure may occur more often than has been reported, and the diagnosis is easily missed, particularly when a history of recent severe exposure to lead is not readily available.

Summary

We have reported the case of a 44-year-old white man with lead encephalopathy after a seven-year industrial exposure. The patient improved remarkably after treatment with CaEDTA.

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Letters to the Editor

Perry R. Ayres, M.D.
Editor
The Ohio State Medical Journal

Dear Doctor Ayres:

I was very much interested in the article by Dr. Kanter on polymyalgia rheumatica (*Ohio State Med J* 69:669-671, 1973). I have been interested in this subject for some years and even more involved in work on temporal arteritis. I cannot agree with the statements Dr. Kanter makes regarding the value of negative temporal artery biopsies. He accepts the concept of segmental dissemination of the arteritis.

A review of more than 1,000 papers in the medical literature failed to reveal a single instance of a documented skip area or segmental involvement in the *temporal* artery in a patient with temporal arteritis proved by biopsy. In addition, in an examination of intermittent tissue sections from 6½ feet of positive temporal artery biopsies, there were no skip areas nor any evidence of patchy or segmental involvement.[1] This is important both in making the diagnosis of temporal arteritis and excluding it.

The dose of steroid therapy for polymyalgia rheumatica may be small and innocuous, but the

therapeutic dose for temporal arteritis in which vision—and even life—is threatened, is much higher and represents an additional danger to the patient. We feel that the sine qua non for the diagnosis of temporal arteritis which will commit the patient to a dangerous therapeutic regimen must be a positive temporal artery biopsy. Moreover, a negative biopsy excludes this disease in almost every instance.

We also must take exception to the suggested dose of only 40 to 60 mg of prednisone recommended for the treatment of temporal arteritis. In fact, several patients have gone on to lose vision and have even died on this inadequate level of treatment during the most active phase of the disease, and we recommend doses in the range of 100 mg of prednisone in daily divided doses during the acute stage of temporal arteritis. In the older group of patients in whom temporal arteritis is likely to be diagnosed, it is imperative that the diagnosis be established without a doubt in order to avoid an unnecessary course of high-dose, long-term steroid therapy.[2]

Finally, I must stress that temporal artery biopsies are also important in differentiating occult temporal arteritis, which shows no signs or symptoms of cranial arteritis from polymyalgia rheumatica. Making a diagnosis of the former may save the patient from blindness if treatment with a proper dose of steroids is instituted.[2]

Yours very truly,

David N. Cohen, M.D.
Cleveland Clinic
Cleveland, Ohio

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2. Cohen D: Temporal arteritis: improvement in visual prognosis and management with repeat biopsies. *Trans Am Acad Ophthalmol Otolaryngol* **77**:74-85, 1973.

March 31, 1974

Editor
The Ohio State Medical Journal

Dear Dr. Ayres:

With regard to the letter by Dr. David N. Cohen concerning my article on polymyalgia rheumatica, I feel that Dr. Cohen misinterpreted the scope of my paper. I was simply reviewing the then current literature and not relying on any of my own clinical experience or laboratory work. Therefore, the argument posed by Dr. Cohen regarding segmental dissemination of temporal arteritis and his disagreement on steroid dosage for the treatment of temporal arteritis cannot be answered by me.

In reviewing some standard textbooks, I found two authors[1,2] who collaborated with the statement by Fauchald, et al[3] that there was segmental distribution of temporal arteritis. Also, a paper by Birkhead, Wagener, and Shick[4] included cases where there was spotty arterial involvement of disease. I refer Dr. Cohen to these sources.

Regarding appropriate steroid dosage for treatment of temporal arteritis, I refer Dr. Cohen to Dr. Fernandez-Herlihy's paper,[5] from which I quoted the steroid dosage.

I thank Dr. Cohen for his interest and expression of his opinion and new work with temporal arteritis. Had his then unpublished work on skip areas in temporal arteritis been available when I wrote my paper, I feel I would have included it. However, only the authors mentioned herein, and not myself, can give meaningful discussions to the disagreements posed by Dr. Cohen.

Sincerely yours,
Steven F. Kanter, M.D.
Phoenix, Arizona

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April 5, 1974

Editor
The Ohio State Medical Journal

Dear Dr. Ayres:

Dr. David Cohen seemed to have missed the point of Dr. Kanter's article in that it was simply a review of the literature. In that sense, Dr. Kanter didn't make any "statements" and he didn't "accept any concepts." The two papers to which Dr. Cohen referred Dr. Kanter and authored by Dr. Cohen were not available at the time Dr. Kanter's paper was written. As he indicates, one of them was "in press" and the other was just recently published. Therefore, it would have been unusually difficult for Dr. Kanter to have quoted from these.

Sincerely yours,
Norman O. Rothermich, M.D.*
Columbus Medical Center
Columbus, Ohio 43215

*Dr. Rothermich sponsored the paper by Dr. Kanter, who was a medical student at the time the paper was submitted.

Professional Activities



Proceedings of The Council

Meeting of March 9-10, 1974

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday and Sunday, March 9-10, 1974, at the OSMA Headquarters' office, 17 S. High Street, Columbus, Ohio. Those present Saturday were: All members of The Council (with the exception of Robert E. Rinderknecht, M.D.); John H. Budd, M.D., Cleveland, a member of the AMA Board of Trustees; Mr. James E. Pohlman, Columbus, OSMA Legal Counsel; Mr. James S. Imboden, Columbus, Assistant Director of the AMA Public Affairs Division; Mr. William J. Lee, Columbus, Administrator, Ohio State Medical Board; John W. Cashman, M.D., Columbus, Ohio Director of Health; Henry G. Cramblett, M.D., Columbus, a member of the Ohio State Medical Board; Drs. Richard L. Fulton, Columbus; P. John Robechek, Cleveland, and Robert N. Smith, Toledo, all members of the Ohio Delegation to the American Medical Association; Walter H. Maloney, M.D., Cleveland, representing the AMA Section on Otorhinolaryngology; Messrs. Page, Edgar, Campbell, Clinger, Rader, Houser, Mrs. Wisse, Mr. Moore, and Mrs. Dodson, of the OSMA Staff.

Those present Sunday were: All members of The Council (with the exception of George N. Bates, M.D. and Dr. Rinderknecht); Mr. Pohlman, Mr. Imboden, Dr. Robechek, and all members of the OSMA Staff.

Announcements by President

The President presented to the Council:

A letter, dated February 8, 1974, from Robert D. McGrail, Vice-President for Sales, ITT Sheraton Corporation of America;

A communication, dated February 28, 1974, from John W. Cashman, M.D., Ohio Director of Health, concerning energy decisions as they might affect environmental protection . . . this being a resolution from the Ohio Comprehensive Health Planning Advisory Council;

A letter from James B. Cardwell, Commissioner of Social Security, dated February 25, 1974, replying to Dr. Clarke's protest against preadmission certification;

A letter, dated January 24, 1974, from President Clarke to William E. Simon, Administrator of the Federal Energy Office, and concerning the necessity of fuel allocations to physicians;

A letter from Richard E. Hartle, M.D., to the county medical societies in the Eighth District;

A letter from President Clarke to Caspar W. Weinberger, Secretary, Department of Health, Education, and Welfare, dated March 4, 1974, pointing out that generic prescribing, which has been proposed by Secretary Weinberger, would be detrimental to patient care;

A letter from President Clarke to Charles W. Bates, Director, Ohio Department of Public Welfare, dated February 26, 1974, protesting the inclusion of a civil rights clause being included in the Departmental agreement with providers.

Minutes of Preceding Meeting

Minutes of the meeting January 19-20, 1974, were approved.

Membership

Membership statistics were presented by Mrs. Wisse.

The Council requested the Membership Department to prepare a promotional package for

"Members in Training," in coordination with the AMA Membership Department.

Fiscal Matters

Dr. Lieber presented the minutes of a meeting of the Auditing and Appropriations Committee. March 10, 1974.

The Council **adopted** the following resolution:

"WHEREAS, the Council deems it to be in the best interest of this Association that its surplus funds be invested in such a manner as to yield the greatest interest subject to the requirements of adequate security and availability of funds as needed; and

"WHEREAS, the Investment Department of The Huntington National Bank of Columbus ('Huntington') can invest such surplus funds in appropriate securities to accomplish such purpose; and

"WHEREAS, it will be necessary to consolidate existing accounts of this Associaiton with the Huntington to permit ease of investment;

"NOW, THEREFORE, BE IT RESOLVED. that the Treasurer of this Association be, and he hereby is, authorized and directed to enter into an agreement with the Huntington whereby the surplus funds of this Association, upon the oral or written request of the Treasurer or Comptroller of this Association, be invested or reinvested by said Huntington's Investment Department in (I) any bonds or other obligations of the United States of America which as to principal and interest constitute direct obligations of the United States of America, (II) obligations of the Federal National Mortgage Association and of the Government National Mortgage Association, (III) obligations of the Federal Intermediate Credit Banks, (IV) obligations of Federal Banks for Cooperatives, (V) obligations of Federal Land Banks, (VI) obligations of Federal Home Loan Banks, (VII) certificates of deposit, bankers acceptances and repurchase agreements of banks or trust companies, including the Huntington, organized under the laws of Canada or the United States of America or any province or state thereof, which have combined capital and surplus of at least $20,000,000 in dollars of the United States of America, and (VIII) commercial paper rated 'prime' or its equivalent by either the National Credit Office, Inc. or Standard & Poor's Corporation, or their successors, and unrated commercial paper of similar quality in which the Huntington is also investing funds held by it in a trust or trusts subject to the jurisdiction of the Probate Division of a Common Pleas Court of the State of Ohio (including any investment in pools of such commercial paper owned by the Huntington). The type, amount and maturity of such investments shall be as specified by the Treasurer or Comptroller. Any such investment made by the Huntington may be purchased from the Huntington; and

"RESOLVED FURTHER, that the Treasurer and Comptroller of this Association be, and they hereby are, authorized to consolidate existing accounts of this Association with the Huntington to permit ease of investment; and

"RESOLVED FURTHER, that the proper officers or employees of this Association are hereby authorized and directed, in the name and on behalf of this Association, or otherwise, to execute all such instruments, documents and certificates and take all such further and other action in connection with the resolutions hereinabove adopted as they may deem necessary, advisable or proper to effectuate the intent and purposes of these resolutions."

The Council **approved** the transfer of funds from the American Bank savings account and certificates of deposit for the purpose of meeting initial construction loan payment.

American Medical Association

Mr. Campbell presented the minutes of the meeting of the AMA Delegation held March 8, 1974.

The Council **approved** the selection of Richard L. Meiling, M.D., as Chairman; Oscar W. Clarke, M.D., as Co-chairman, and P. John Robechek, M.D., as Vice-Chairman.

The Council **approved,** for introduction at the June meeting of the American Medical Association, a resolution with regard to the membership of interns and residents.

The Council **approved** the recommendation of the Delegation that the Ohio State Medical Association nominate, on behalf of the Academy of Medicine of Columbus and Franklin County, Robert M. Zollinger, M.D. for the Sheen Award of the American Medical Association.

Other recommendations **approved** by the Council were as follows:

(1) Nomination of Tennyson Williams, M.D., Delaware, for Board of Directors of the American Board of Family Practice.

(2) The reappointment of Irvine H. Page, M.D., to the Advisory Committee on Medical Sciences; Robert E. Reiheld, M.D., to the Council on Rural Health, and Henry A. Crawford, M.D., to the Advisory Committee on Cancer.

(3) Nominations of the following to committees of the American Medical Association: Robert C. Waltz, M.D., Committee on Community Emergency Services; Arnold Leff, M.D., Committee on Drug Dependency: John E. Albers, M.D., Council on Scientific Assembly; Mary M. Martin, M.D., Committee on Transfusion and Transplantation: Viola V. Startzman, M.D., Committee on Mental

Health; Robert J. Murphy, M.D., Committee on Sports Medicine; Esther C. Marting, M.D., Committee on Health Care of the Poor; Emily R. Hess, M.D., Committee on Exercise and Physical Fitness; Robert N. Smith, M.D., Council on Legislation.

(4) $250 for "Ohio" badge emblems.

(5) With regard to elections, the Council **approved** support for the election of P. John Robechek, M.D., to the Council on Medical Education, and Robert E. Tschantz, M.D., Council on Medical Service.

OSMA Annual Meeting

Mrs. Dodson reported on the progress and plans for the OSMA Annual Meeting.

The President appointed, with the approval of Council, the following judges of scientific exhibits: Jerry L. Hammon, M.D., Columbus, and Councilors Tye, Morgan and McLarnan.

John H. Budd, M.D., was selected to receive the "Distinguished Service Award" of the OSMA for 1974.

MAI

The minutes of the Board of Trustees of Medical Advances Institute meetings of January 23 and February 27, were presented by Dr. Henry and were accepted for information.

Ohio Medical Indemnity

Dr. Schultz presented the "Operational Highlights" of Ohio Medical Indemnity, Inc., for 1973. The report is attached to the minutes.

Ohio Foundation for Medical Care

Minutes of the meeting of the Board of Trustees of the Ohio Foundation for Medical Care, held on March 6, were presented by Mr. Rader and were accepted for information.

Committee Reports

Committee on Maternal Health

Minutes of the meeting of the Committee on Maternal Health, January 19-20, were presented by Mrs. Dodson, and were **approved.**

A resolution directed to the Ohio Department of Health, with regard to the necessity to revise the Maternity Licensure Regulations, was **approved** by the Council for forwarding to the Ohio Director of Health.

The Council **approved** the Committee's recommendation that its chairman forward, to the Ohio Director of Health, a copy of Resolution 49-73, of the OSMA House of Delegates with regard to Maternity Hospital Regulations.

The minutes, as a whole, **were approved.**

Committee on Health Manpower

Minutes of the meeting of the Committee on Health Manpower of January 27, were presented by Mr. Clinger.

The Council **approved** the recommendation of the committee that OSMA adopt the definition of Physician's Assistant found on page 5 of the AMA booklet "Employment and Use of Physician's Assistants—a Guide for Physicians," as follows:

"The physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."

The Council also approved the committee's recommendation that before firm proposals are finalized and forwarded concerning physician's assistants, the county medical societies be polled as to their positions on legislation in this field.

Ad Hoc Committee on Complaint Procedures

The minutes of the Ad Hoc Committee on Complaint Procedures meeting of January 30, were presented by Mr. Campbell and were accepted for information.

Ohio Cancer Coordinating Committee, Inc.

Minutes of the Ohio Cancer Coordinating Committee meeting of February 1-3, were presented by Mr. Clinger.

The PAP Test statement on Page 3 of the minutes was amended by deleting the words, "required at admission to" and inserting in lieu thereof, "encouraged prior to and during hospitalization in." This had to do with the endorsement by the OSMA of the project "Let No Woman Be Overlooked" and the amended statement reads: "PAP Tests for uterine cancer should be encouraged prior to and during hospitalization in all Ohio hospitals for all females over 20, or others at risk."

A statement on a Cervical Cancer Project of the Ohio Department of Health was re-referred to the committee for re-evaluation and clarification.

The minutes, as amended, **were approved.**

Committee on Laboratory Medicine

Minutes of the meeting of the Committee on Laboratory Medicine of February 12, were presented by Mr. Rader.

The Council **approved** the committee's recommendation that S.B. 412, to mandate premarital testing for gonorrhea, be opposed.

Dr. Thomas reported on his meeting with John W. Cashman, M.D., Ohio Director of Health, and John H. Ackerman, M.D., Director, Division of Communicable Diseases, with regard to amending the prenatal gonorrhea testing law.

Minutes of the meeting of the Committee on

Laboratory Medicine of February 27, were presented by Mr. Rader.

The Council **approved, in principle,** the committee's suggested policy:

"1) Support the concept of registration of all laboratories providing medical testing in the State of Ohio in a form similar to that attached; and

"2) Based on information gathered from this registration that the Laboratory Medicine Committee of the OSMA be charged with:

"1) Determining if there are any problems in Ohio in guaranteeing quality of laboratory work; and if so

"2) To propose any necessary remedial legislation to attempt to solve this problem."

The Council directed that any bill prepared in accordance with the above be checked with legal counsel and circulated to the OSMA Council prior to introduction.

Committee on Health Care of the Poor

Minutes of the meeting of the Committee on Health Care of the Poor of February 20, were presented by Mr. Houser.

The President was instructed to communicate with the Director of the Ohio Department of Public Welfare concerning the Ohio Crippled Children's Bureau not being in compliance with federal requirements.

Other matters were referred to the Committee on Government Medical Care Programs for study.

Joint Advisory Committee on Sports Medicine

Minutes of the meeting of the Joint Advisory Committee on Sports Medicine, February 20, were presented by Mr. Clinger.

The Council **approved** the proposal that the committee issue guidelines for model non-catastrophic school athletic insurance programs.

The Council referred to the Committee on Insurance the committee's recommendation to "strongly recommend to major Ohio insurance companies that they initiate programs of reimbursement for office calls for the purpose of treating athletic injuries—and that such reimbursement be included for diagnostic x-rays."

The minutes of the committee, as a whole, **were accepted.**

Committee on Emergency and Disaster Medical Care

The minutes of the meeting of the Committee on Emergency and Disaster Medical Care, February 23, were presented by Mr. Rader.

The Council accepted the committee's recommendation that S.B. 377, to establish standards for emergency vehicles and personnel who operate them, be **approved in principle.**

Also **approved** was the committee's recommendation that hospital emergency capabilities be categorized in larger metropolitan areas and the larger county medical societies be asked by the OSMA to study categorization of their emergency rooms.

A Cincinnati problem on categorization was referred to the Joint Officers Conference of the Ohio State Medical Association/Ohio Hospital Association/Ohio Osteopathic Association of Physicians and Surgeons.

The report, as a whole, **was accepted.**

Commission on Medical Education

The minutes of the meeting of the Commission on Medical Education, March 6, were presented by Mr. Edgar.

The Council **approved** in principle the recommendations of the Commission and requested the guidelines and a cost estimate before implementation.

Council Fee Review Committee

The minutes of the Council Fee Review Committee meeting, March 8, were presented by Mr. Campbell, and **were approved** by the Council.

Other Meetings

Other meetings attended by the members of the Council and staff were discussed.

Councilor Reports

The Councilors reported on activities in their respective districts.

Federal Legislation

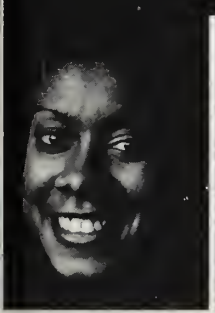
Mr. Edgar referred members of the Council to a comparison of national health care legislative proposals provided to Councilors for use in discussing the contents of the various bills. He also reported that the House had passed its version of a pension and retirement bill previously passed by the Senate, and that a joint conference committee would be necessary to resolve the differences in the two versions. He said the legislation liberalizes retirement programs for both the self-employed and the employed.

State Legislation

Sub. H.B. 989, to establish abortion guidelines. The bill has been extensively amended in the Senate Judiciary Committee and now includes three new abortion-related crimes: for non-consensual abortion; for abortion manslaughter, and for abortion trafficking. Although other objectionable medical features have been removed, the Council voted to continue opposition of the bill on the basis of the unfair jeopardy and burdens placed upon physicians by the newly created crimes.

(Continued on Page 331)

types for Tylenol®
(acetaminophen)



The patient with asthma or allergy



The patient with gastritis



The patient on uricosurics



The patient on anticoagulants



The peptic ulcer patient



The febrile, dehydrated child

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When one of the types of patients pictured above needs an analgesic, you have another 'type for TYLENOL (acetaminophen)'— a person who should avoid aspirin.

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If a rare sensitivity reaction occurs, the drug should be stopped.
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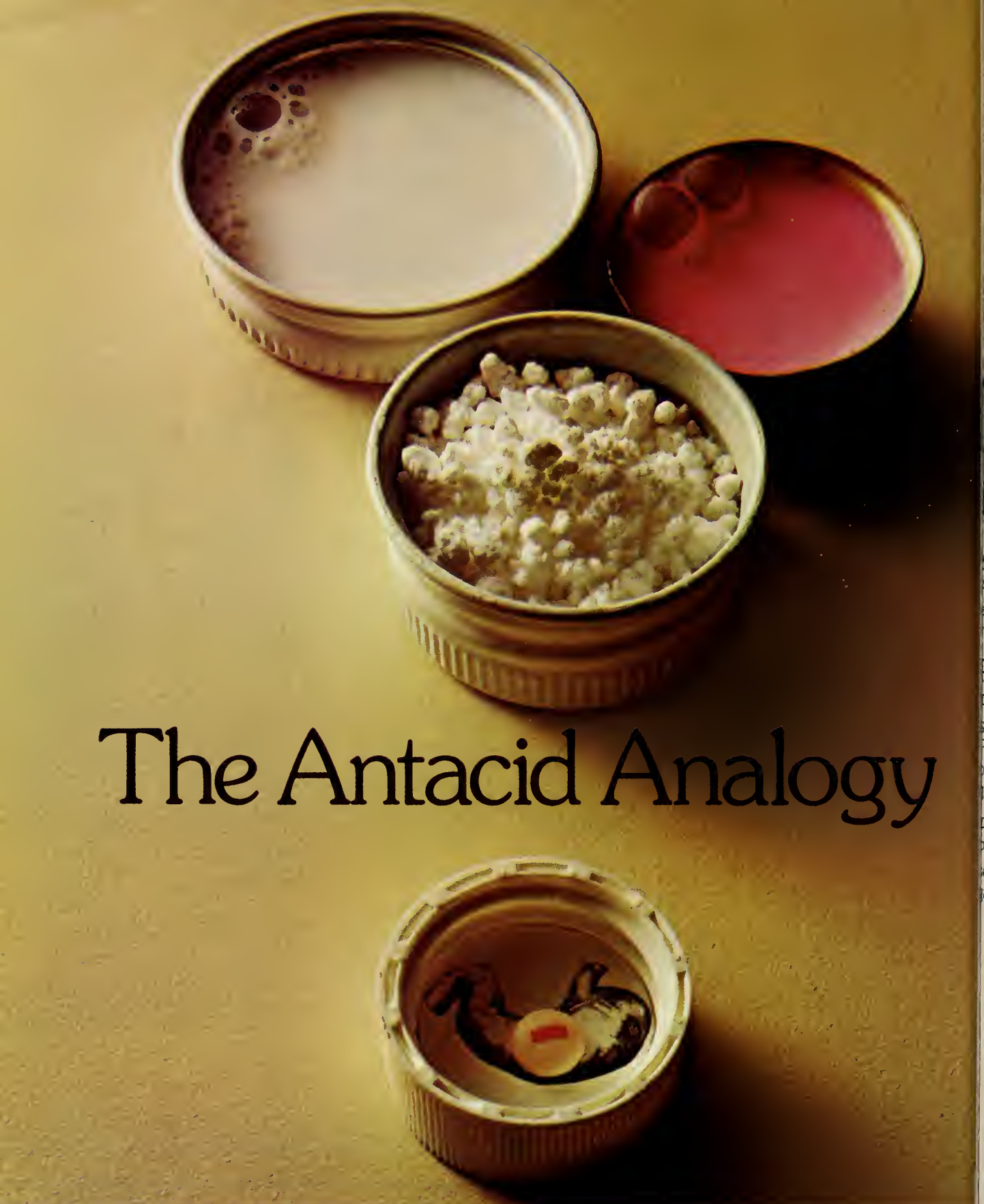
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The Antacid Analogy

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

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Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may

Therapeutic comparisons in peptic ulcer.

Antacids have only one mode of action to relieve ulcer pain...

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Antacids:

ntacids relieve ulcer pain by neutralizing gastric cid. This action is relatively short-lived and they have o other mode of action.

Pro-Banthine:

Pro-Banthine suppresses gastric acid ecretion. The antisecretory properties of ro-Banthine are well established. By effectively locking vagotonic impulses Pro-Banthine suppresses astric secretion to reduce both total and free acid.

Pro-Banthine helps relieve pain. ro-Banthine relieves ulcer pain by reducing gastric ecretion and the motility and spasm of the astrointestinal tract.

Pro-Banthine reduces acidity without subsequent acid rebound. The capacity of Pro-Banthine to reduce the secretion of total and free acid in the stomach has been demonstrated in scores of studies. None has demonstrated any significant evidence of acid rebound.

Pro-Banthine activity lasts about six hours. The effect of a single therapeutic dose (15 mg.) of Pro-Banthine lasts about six hours.* Pro-Banthine P.A.®, the prolonged-acting form, is active from 8 to 12 hours. Thus Pro-Banthine may be used to suppress acid, spasm, and pain around the clock, even during the sleeping hours when antacids, to be effective, must be taken almost hourly.

*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

Pro-Banthine complements and enhances the action of antacids.

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cur as well as mydriasis and blurred vision. In addition the following lverse reactions have been reported: nervousness, drowsiness, dizziness, somnia, headache, loss of the sense of taste, nausea, vomiting, constipa-n, impotence and allergic dermatitis.

osage and Administration: The recommended daily dosage for adult al therapy is one 15-mg. tablet with meals and two at bedtime. Subse-ient adjustment to the patient's requirements and tolerance must be ade.

o-Banthine P.A.—Each tablet of Pro-Banthine P.A. (propantheline omide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthine 15 mg. should be observed.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

Synthroid®

(sodium levothyroxine)



Supplied: **Tablets**: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded in bottles of 100, 500, and 1000.

Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent.

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H.B. 1018, to permit funeral directors and embalmers to enucleate eyes. Council voted to support.

H.B. 1175, to revise emergency medical treatment authorization form school districts are required to provide to parents and keep on file. Council voted to support the concept of the Bill.

H.B. 1176, to modify state support payment to non-Ohio resident medical students. Council took no position.

S.B. 484, to increase state support for resident students in state medical schools. Council took no position.

S.B. 498, to authorize contraceptive and pregnancy advice and treatment for minors without parental consent. Council voted active support of the bill.

H.B. 1134, Am. S.B. 206, S.B. 474 and **S.B. 482,** "Energy Bills." Council asked to make certain that physicians' energy needs are met.

Constitution and Bylaws

The Council **approved** the reissuance of the Charter of the Mahoning County Medical Society.

Legal Counsel Reports

Mr. Pohlman announced that the Ohio Supreme Court had recently ruled in favor of the position taken by the Ohio State Medical Board and the Ohio State Medical Association in the *DeMido* case, in which the OSMA and others had filed *amicus curiae* briefs.

Mr. Pohlman advised the Council that there has been no indication that the American Medical Academy had ceased its infringement of the American Medical Association name and logotype and that the Office of the General Counsel of the AMA was being kept closely advised.

Project U.S.A.

It was the Council's decision in this matter that local societies have the responsibility to present Project U.S.A. plaques.

Medical Examiner

Correspondence with regard to the use of the words "Medical Examiner" with regard to life insurance examinations was referred to the Ohio State Medical Board.

Amicus Curiae with AMA on Phase IV

The Council delayed a decision with regard to the possibility of entering, amicus curiae, in the AMA's suit against the Director of HEW involving Phase IV price control regulations.

U.S. Pharmacopeia

William H. Havener, M.D., Columbus, was selected by the Council to represent the Ohio State Medical Association at the United States Pharmacopeial Convention in 1975.

Women's Auxiliary Bylaws

Proposed changes in the Bylaws of the Woman's Auxiliary to the Ohio State Medical Association **were approved** by The Council.

Ohio Director of Health

John W. Cashman, M.D., Ohio Director of Health, addressed the Council. He discussed the revisions of the Maternity Hospital Regulations, which will "be in final form soon."

Dr. Cashman reported that the Governor's Task Force Report is not yet in print and that it will have 200 to 300 pages with technical backup material.

He said that the Comprehensive Health Planning Council is ready to implement Section 1122, which he said is certification of need. The guidelines will be ready in several weeks, following which a public hearing will be necessary.

He asked the Council for a suggestion with regard to a medical doctor to serve on the Comprehensive Health Planning Council.

Ohio State Medical Board Report

Henry G. Cramblett, M.D., President of the Ohio State Medical Board appeared before the Council and discussed H.B. 1008, which involves the licensing of American citizens who graduate from foreign medical schools. It was determined that amendments prepared by the Ohio State Medical Association were very similar to those proposed by the Ohio State Medical Board and the Ohio medical school deans.

ATTEST: Hart F. Page
Executive Director

Ohio State Medical Association Committees at Work

Emergency and Disaster Medical Care Committee

The Emergency and Disaster Medical Care Committee has met twice so far in 1974. The first meeting was at the Ohio Educational Television Network Headquarters where the Committee reviewed Ohio ETV Network learning how two-way audio and video communications between the physicians in local hospitals and physicians at the Ohio State University might be utilized during emergency situations.

The Committee has also been involved in advocating categorization of emergency rooms in major metropolitan areas and has published an article in the February issue of the *Ohio State Medical Journal* to this effect. Members of the Committee have been working on development of the Ohio Emergency Medical Coordinating Council which consists of members of the Ohio Department of Health and other state and public agencies concerned with emergency medicine. This Coordinating Council is an effort on the part of organized medicine and the public and private sectors of the state to provide best quality emergency health care.

Committee on Laboratory Medicine

The Committee on Laboratory Medicine has met three times so far in 1974. Topics of discussion by this Committee include an effort to deal with the new state law requiring premarital gonorrhea testing and an effort to respond to legislation that has been introduced to license laboratories. The Committee has developed a laboratory registration bill which is to be introduced in the Ohio Legislature which will allow for data gathering as an alternative to laboratory licensure. The Committee has also recommended that the members of the OSMA participate in the College of American Pathology Efficiency Evaluation Program for physician's offices laboratory work.

Ohio Foundation for Medical Care

The Ohio Foundation for Medical Care, an incorporated unit of the Ohio State Medical Association, has had three meetings of its Board of Trustees during 1974. The Board of Trustees are involved now in carrying out the mandate of the OSMA House of Delegates to create local and regional foundations to provide an alternative health care delivery system to "close panel" prepaid salary HMO's. The Committee has been working with a consultant, American Health Systems, Inc., to provide the funding and to establish procedures within the state.

Council Fee Review Committee met on March 8 and made recommendations to The OSMA Council regarding six cases submitted by various third-party carriers.

Ad Hoc Committee to Review Complaint Procedures met on January 30 with representatives of six third-party carriers and interested parties regarding fee complaint procedures. Comments by those in attendance were very helpful to the Committee in planning the future course of the committee's deliberations. Comments regarding the review system included:

1. The time it takes to review a case;
2. The review system should include utilization review; and
3. Guidelines for review should be provided to county medical societies.

The Council Fee Review Committee and the **Ad Hoc Committee to Review Complaint Procedures** held a combined meeting on March 8 to assist the Ad Hoc Committee in its deliberations and to determine the future role and responsibility of the Council Fee Review Committee.

Uterine Cancer Project Receives OSMA Endorsement

OSMA Council has approved a recommendation by the Ohio Cancer Coordinating Committee, Inc. that OSMA endorse the American Cancer Society's anti-uterine cancer project "Let No Woman Be Overlooked." The goal of this project is a PAP Test by 1976 for every woman 20 years or older to whom the test is applicable and for younger women at risk.

Council also gave approval to the following OSMA policy statement:

"PAP Tests for uterine cancer should be encouraged prior to or during hospitalization in all Ohio hospitals for all females over 20 to whom the test is applicable, or others at risk."

Council also approved the Committee's recommendation that OSMA endorse an anti-cervical

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Unique design. In shape, size and color, CAMA looks like no other aspirin. It gives patients an "individualized" medication—one they may find more acceptable and possibly respond to more positively.

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cancer program proposed by the Ohio Department of Health. It cautioned, however, that both the American Cancer Society and Ohio Department of Health should coordinate their efforts in the two programs in order to avoid unnecessary duplication. It was also recommended that as many other medical, paramedical and lay organizations be involved as possible.

Council also approved the following recommendations of the Ohio Cancer Coordinating Committee, Inc.:

1. That OSMA not support individual proposals for comprehensive cancer research centers in Ohio—but rather urge the selection of one or more sites in Ohio on the basis of the state's status as a key location for medical expertise and concentration of population.

2. That a proposal be prepared for a study of the incidence and prevalence of childhood cancer in Ohio as a pilot project.

Athletic Team Physicians To Be Honored by Exhibit at 1974 OSMA Annual Meeting

Ohio physicians who devote many hours of "leisure" time to serving scholastic athletic teams will be honored in a special exhibit at the 1974 OSMA Annual Meeting, May 12-15 in Cleveland. The exhibit will be sponsored by the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association.

The exhibit will contain a listing of Ohio high schools, their team physicians and the length of service for each physician. This information has been obtained by the Joint Advisory Committee through a survey of member schools conducted by the OHSAA. At presstime approximately 90 percent of the schools had responded to the survey.

Sol Maggied, M.D. of West Jefferson, who will step down as chairman of the Joint Advisory Committee during the 1974 Annual Meeting after five years in the post, pointed out that the exhibit will serve three basic purposes:

1. Give long overdue and well-deserved recognition to hundreds of hard-working athletic team physicians—both M.D. and D.O.—in Ohio;

2. Give team physicians who may have been overlooked during the survey an opportunity to list their team and length of service while visiting the exhibit;

3. Initiate a placement service between more than 150 Ohio high schools which have no team physician or medical coverage during athletic contests with physicians who may be willing to provide their services as team physicians.

The Joint Advisory Committee also plans to issue guidelines soon for model noncatastrophic athletic insurance programs to Ohio schools. The Committee during its February 20, 1974 meeting recommended that the OSMA Committee on Insurance strongly urge major Ohio insurance companies to initiate programs of reimbursement for office calls for the purpose of treating athletic injuries—and that such reimbursement be included for diagnostic X-rays.

AMA Delegation Meeting

The Annual Meeting of the Ohio Delegation to the American Medical Association was held on March 8. Ohio's nine Delegates and Alternate Delegates will represent the Ohio State Medical Association at the AMA Annual Convention in Chicago, June 22-27.

The following recommendations were made to the OSMA Council:

1. That Richard L. Meiling, M.D., Columbus, serve as Chairman of the Delegation and that P. John Robechek, M.D., Cleveland, serve as Vice-Chairman. The OSMA President is ex-officio Co-Chairman of the Delegation.

2. That Harry K. Hines, M.D., Cincinnati, be appointed chairman of the Committee on Hospitality; Lawrence C. Meredith, M.D., Oberlin, be appointed chairman of the Committee on Resolutions; and Robert E. Tschantz, M.D., Canton, be appointed chairman of the Committee on Elections and Candidates.

3. That a resolution be submitted to the AMA Annual Meeting in Chicago, June 22-27, regarding intern and resident membership.

4. That Robert M. Zollinger, M.D., Columbus, be nominated for the 1974 AMA Sheen Award.

5. That Tennyson Williams, M.D., Delaware, be nominated to the American Board of Family Practice Board of Directors.

6. That eleven physicians be nominated to various AMA Councils and Committees.

7. That the Ohio State Medical Association support P. John Robechek, M.D., Cleveland, for nomination and election to the AMA Council on Medical Education and that OSMA also support Robert E. Tschantz, M.D., Canton, for nomination and election to the AMA Council on Medical Service.

The next meeting of the Ohio Delegation is scheduled for May 14, 1974, at the Cleveland-Sheraton Hotel, during the OSMA Annual Meeting.

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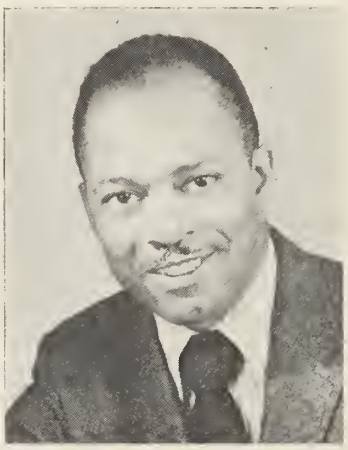
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Toledo Physician Is Named to State Medical Board

ANNOUNCEMENT HAS BEEN MADE that Governor John J. Gilligan has appointed to the State Medical Board Roland A. Gandy Jr., M.D., of Toledo. The eight-member board is the agency charged with the responsibility of licensing physicians and other practitioners and enforcing the law as it applies to the healing arts in Ohio.



Roland A. Gandy, Jr., M.D.

A general surgeon, Dr. Gandy has served most of his professional career in Toledo. He graduated from Temple University School of Medicine, Philadelphia, in 1951 and passed the National Board examinations the following year. He was licensed in Ohio in 1956 and has been a member of the Ohio State Medical Association and the American Medical Association since the early part of his practice.

He is a diplomate of the American Board of Surgery, a Fellow of the American College of Surgeons and is on the surgical faculty of the Medical College of Ohio at Toledo.

Long interested in medical organization work, Dr. Gandy has been active in the Academy of Medicine of Toledo and has served that organization in many capacities. He was last year's president of the Academy, and has been one of the Academy's delegates to the OSMA. In addition, he has served on reference committees of the House. Among current appointments on the state level, he is a member of the OSMA Committee on Legislation.

Dr. Gandy succeeds Dr. Ralph K. Ramsayer, of Canton, whose term of office expired this year. Dr. Ramsayer was first appointed to the State Medical Board in 1965 to fill part of an unexpired term and was later reappointed for a full term.

A practicing physician of long standing in Canton, Dr. Ramsayer's specialty is obstetrics and gynecology. He is a past president of the Stark County Medical Society, and has served the Society in many other capacities. On the state level he has served as a delegate to the OSMA House of Delegates and served for a number of years on the OSMA Committees on Scientific Work and on Maternal Health.

Other members of the Medical Board are Anthony Ruppersberg, Jr., M.D., Columbus; Henry A. Crawford, M.D., Cleveland; Peter Lancione, M.D., Bellaire; John D. Brumbaugh, M.D., Akron; Henry G. Cramblett, M.D. Columbus; Sanford Press, M.D., Steubenville; and William J. Timmins, D.O., Warren, the Osteopathic representative on the Board. William Lee, Attorney, is Administrator of the Board.

Officers of the Board are Dr. Cramblett, President; Dr. Ruppersberg, Vice-President and Secretary; and Dr. Brumbaugh, Treasurer.

PHYSICIAN WANTED

The Near West Side Area Commission, Columbus, is looking for a doctor to man a proposed Health Center. Agreement has been reached between the commission and Dr. William Brown, Head of the Columbus Health Department, for establishment of a Health Center. The doctor would provide for primary health care on a 40-hour a week basis and would receive a $35,000 annual salary. Interested physicians should contact William Brown, M.D., Health Commissioner, Columbus Health Department, 181 Washington Blvd., Columbus 43215; phone 614/461-7417.



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OSMA Annual Meeting a Common Interest with Your Colleagues

THE Ohio State Medical Association's Annual Meeting scheduled in Cleveland, May 12-15 furnishes a common meeting place for Ohio physicians in every branch of practice and in every professional pursuit. In the program will be found continuing medical education programs of most value to the largest number of OSMA members.



Oscar W. Clarke, M.D.
President, Ohio State Medical Association

You're probably asking, What's in this Annual Meeting that would prompt me to break away from a busy schedule? In response to that question, let's examine a few of its features.

The 1974 Annual Meeting is three days of continuing education courses. Under the general theme, "Cycles of Life and Health" you will find of particular interest an all-day program on Monday, "Vascular Diseases from Infancy to Old Age." This series of symposia will present discussions by outstanding panels on "Clues to Vascular Disease at All Ages," "Hyperlipidemias of All Ages," "Hypertension," and "Cerebrovascular Insufficiency."

On Wednesday there will be another all-day program entitled, "Run for Your Life." Here again an outstanding panel of speakers will discuss exercise in relationship to the health of your patients.

If you are accumulating credit under the American Medical Association Physician's Recognition Award, or the American Academy of Family Physicians program, or if you need to update your knowledge in one of these subjects, look over the Tuesday and Wednesday program of Six Postgraduate Courses. Courses are continued on two successive days so physicians can fit attendance into a busy schedule. Numerous other programs are available also.

The 1974 Annual Meeting will contain an excellent exhibit. Ohio has become known for its outstanding exhibit. Of special interest this year is an open house on Monday evening, an exclusive period for physicians to view the exhibits. Many doctors have expressed a desire to have the exhibits open in the evening when programs are not scheduled. In the exhibit hall you will find scientific exhibits manned by your colleagues ready to discuss their projects with you. You will find health education exhibits, and technical exhibits, the latter manned by detail men ready to discuss their products and services.

The Art Show is another feature you'll enjoy. Many physicians are artists in their own right, as well as members of their families. Dr. Victor Laughlin, of Cleveland, is working diligently to present an outstanding Art Show for your enjoyment.

The Annual Meeting is the OSMA business meeting of the year. The House of Delegates meets on Sunday evening, May 12 and again on Wednesday afternoon. On Monday reference committees of the House meet to hear arguments on some 50 resolutions that may help to determine policy of the Association. Any member is privileged to appear before these committees and discuss the subjects at hand.

The Annual Meeting is a time for luncheons, dinners, and other meetings of special groups who may have business to discuss or matters of internal interest.

The Annual Meeting will present "OSMA's Olde but Goode Night" on Tuesday evening. This is the social highlight of the meeting, a time to relax and enjoy a period of entertainment with your friends. Busses will leave the Sheraton-Cleveland Hotel and go to the Frederick C. Crawford Auto-Aviation Museum where cocktails, buffet dinner and dancing will be enjoyed.

The Annual Meeting is something in common for you and your colleagues. No matter how good the program or what weighty matters the House of Delegates has to consider, an important element

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of the Annual Meeting is the satisfaction of getting together with your colleagues. The conscientious physician is ever aware that he is dependent upon his fellow physicians—for discussion of common problems, for information on developments, and for support in dealing with difficult situations.

Furthermore, a strong Annual Meeting is an indication of a strong Association. In this age when encroachments on the prerogatives of medicine are becoming stronger, physicians must unite their strength in one organization, and in Ohio that organization is the Ohio State Medical Association.

Join us in Cleveland, May 12-15, spend three days with your colleagues throughout Ohio, and help strengthen your Ohio State Medical Association.

Oscar W. Clarke, M.D.
President,
Ohio State Medical Association

Support for OMPAC-AMPAC Vital This Election Year

A. Burton Payne, M.D.
Chairman, OMPAC Membership Committee

PERHAPS never in its history has the Ohio Medical Political Action Committee (OMPAC) and the American Medical Political Action Committee (AMPAC) faced a more crucial election year. Not only for members of these organizations, but for all of medicine, this year's stakes are high.

Public opinion polls tell us that the President's standing with the voters is low and that Congress ranks even lower. It is the public's apparent disenchantment with those in politics that presents an extraordinary challenge this year to those concerned with political action.

Will the voters react with apathy? Or with revenge, that is, a "throw-the-rascals-out" attitude? Or will the voters turn just against the party in power—against the Republicans for the Administration, or against the Democrats who control Congress?

Labor already is urging the voters to elect what it calls a "veto-proof" Congress, as the *Wall Street Journal* comments in part as follows:

". . . The difference this year is the anticipation of a Democratic landslide in November and a 'Veto-proof' 94th Congress next January. It now need only knock out the necessary work on appropriation bills and authorization extensions, with time out for a summer vacation. Better to put off the major issues, according to this thinking, until it is no longer necessary to arrange compromises with the White House. Come January, it will not matter what Republican is in the White House, Congress will be running the country. . . ."

What is OMPAC-AMPAC's — medicine's — challenge? To see that in this election year, candidates who agree with medicine's political philosophy are supported as vigorously as possible and are given every opportunity to win.

How can OMPAC-AMPAC meet this challenge? First, by building membership; second, by organizing candidate support committees.

AMPAC members who attended the AMA-AMPAC Public Affairs Workshop in Washington recently had their priorities spelled out for them, and were exhorted to be especially active this year. Membership means dollars and active volunteers, both of which are essential parts of candidate support committees.

AMPAC's chairman, W. J. Lewis, M.D., Dayton, put it on the line: "Membership is, was, and will be our top priority. We must give it an extra push this year. . . . Every congressional district should have a candidate support committee this year. . . . We must put persuasive, articulate volunteers to work right through election day."

One vital legislative issue that makes this election year so important for medicine is national health insurance. Labor makes no secret of its intention to push for its comprehensive, expensive, compulsory bill, which medicine cannot accept, or of its desire for a "veto-proof" Congress to make it easier to enact that kind of NHI measure.

Medicine must meet this challenge. Fortunately, a viable means to meet it exists—AMPAC, the national organization and OMPAC, in Ohio, with 49 other state political action committees.

Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

THE LOVELY Drake Hotel with its traditional air of elegance will once again welcome to Chicago the Woman's Auxiliary to the American Medical Association. It will be the occasion of the fifty-second annual convention beginning on Sunday, June 23 and continuing through Wednesday, June 26. As always, the national auxiliary is coming up with an exciting program.

The festivities will get off to a happy start on Sunday evening with a reception honoring Mrs. Willard C. Scrivner, president, and Mrs. Howard Liljestrand, president-elect, in the hotel's Gold Coast Room. Monday's luncheon will honor AMA officers, trustees and their wives. At that luncheon, Kenneth G. Sawyer, M.D., president of AMA-ERF, will make the annual AMA-ERF awards presentation. The Tuesday luncheon will honor National Past Presidents and Honorary Members and will feature a breath-taking (so I'm told!) fashion show by Bonwit Teller.

Two evenings of entertainment have also been planned. On Monday, June 24, there will be dinner at the beautiful La Tour, famous Chicago restaurant and then a sightseeing bus trip. On Tuesday, June 25, there will be a theatre-dinner party at one of Chicago's outstanding clubs. And, of course, there will be a very special entertaining introduction to Chicago for young people during the convention week.

The formal business session will get under way Monday morning. No less a personage than Dr. Joyce Brothers, psychologist, will be the keynote speaker. This popular television and radio personality will address the House of Delegates at the opening session. Other convention speakers include Virginia Apgar, M.D., National Foundation vice-president, and Russell B. Roth, M.D., AMA president. And at the afternoon meeting in the Grand Ballroom at 2:30 p.m., the Idea Exchange will hold front center. This is "spotlight-time" for each of the fifty state auxiliaries when their respective presidents highlight their outstanding 1973-74 project. It is a time for absorbing new ideas and evaluating traditional ones. It is a time for learning and judging and then, later, asking questions.

There will be an editors' workshop on Tuesday afternoon under the expert tutelage of Ohio's own Mrs. J. Paul Sauvageot, editor of the auxiliary's national magazine, *MD's Wife*. Mrs. Howard Liljestrand, of Hawaii, and her new officers and directors will be installed on Wednesday, June 26 by Mrs. C. Rodney Stoltz, national past president. And at that afternoon's panel on national programs, Ohio will again be represented. The guest speaker will be Robert Kaplan, Ph.D., professor and Chairman, Health Education Division, Ohio State University.

The children's program of entertainment covers three days—Monday, Tuesday and Wednesday. They will be divided into two age groups for the first two days—ages 6 to 8 and ages 9 to 14. On the third day, the two groups will be together to visit the Navy Pier, Academy of Science, Lincoln Park Farm in the Zoo and will include luncheon. The cost of that is $10.50 for one child, $8.50 each for two or more in a family.

On Monday the younger group will visit the Chicago Fire Academy, Field Museum, Hancock building, Chicago Odyssey multi-media, luncheon included—$13.50 one child; $11.50 each two or more. On Tuesday this same group will visit the Museum of Science and Industry, Chinatown, Brookfield Zoo, luncheon included. The cost—$13.50 one child; $11.50 each for two or more.

On Monday the older group will have a bus trip to New Salem, the village where Lincoln lived as a young man, and Springfield, state capital and site of many Lincoln shrines. Luncheon and dinner included—$18.75 one child; $16.75 each two or more. On Tuesday this group will visit the Hancock Building, Chicago Fire Academy, Museum of Science and Industry and the U505 Submarine and the coal mine, ending the day in Old Town at the Chicago Odyssey. The cost—$13.50 for one child; $11.50 each for two or more. There will also be a shorter tour on Sunday, June 23 starting at 4:00 p.m. for both age groups.

June is still a month away, but believe me it isn't too early to get your reservations in for all the "happenings." Get going—to Chicago!

Very Worth Noting

Convention will probably be over by the time this column is read in May, but proud mention must certainly be made of the magnificent Physicians' Art Show (for the wives too) held at the 1974 annual meeting in Cleveland under the dedicated direction of Victor G. Laughlin, M.D., general chairman. The June issue of *The Journal* will detail more on this outstanding and beautiful undertaking and the part played by the **Cuyahoga County** auxiliary.

Continuing Education Opportunities for Physicians in Ohio

May

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106:

Plastic Surgery for the General Surgeon — May 8-9.

Advances in Antibiotics and Infectious Diseases — May 22-23.

Ohio State University College of Medicine, Continuing Medical Education Conferences; for details contact OSU Center for Continuing Medical Education, 410 W. Tenth St., Columbus 43210:

Blood Therapy — May 8.

Gynecologic Endoscopy—St. Luke's Hospital, Cleveland; May 8-9; fee $150; contact Amir H. Ansari, M.D., Div. of Reproductive Physiology, Dept. of Obstetrics and Gynecology, 11311 Shaker Blvd., Cleveland 44104; phone 216/791-1000, Ext. 360.

University of Cincinnati College of Medicine, Office of CONMED, 114 Medical College Bldg., Cincinnati 45219:

Life-Saving Measures for the Critically Injured — Sponsored by *American College of Surgeons Committee on Trauma* in cooperation with UC, at the Shriner's Burns Institute, 202 Goodman St., May 8-10.

Speech Pathology — At the Shrine Burns Institute, May 10.

Abdominal Surgery — At Shrine Burns Institute, May 15-16.

Midwest Ophthalmology Symposium — At Shrine Burns Institute, May 17-18.

Recent Advances in Reproductive Physiology —St. Luke's Hospital, Cleveland; May 10; fee, $75; residents, $35; contact Amir H. Ansari, M.D., Div. of Reproductive Physiology, Dept. of Obstetrics and Gynecology, 11311 Shaker Blvd., Cleveland 44104; phone 216/791-1000, Ext. 360.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Seminars on Fundamentals of Surgery — Sponsored by the Medical College of Ohio at Toledo, Saturdays, 10:00 a.m. to noon; Room G-1, MCO; **Gastrointestinal System,** May 4; **Trauma,** May 11, 18.

Symposium on Pediatric Trauma — at the Medical College of Ohio at Toledo (West Campus), May 17-18; cosponsored by Ohio Committee on Trauma, American College of Surgeons; American Trauma Society, Ohio Chapter; Toledo Pediatric Society and Toledo Surgical Society.

Conference on Medical Education—Sponsored by area health education networks in Youngstown and Akron; at Punderson Manor House, Newbury; distinguished faculty, including representatives of the AMA Council on Medical Education; open to directors of medical education and administrators throughout Ohio; May 18; contact C. Kenneth Proefrock, executive director, Mahoning-Shenango Area Health Education Network, Suite 340, 5211 Mahoning Ave., Youngstown 44515.

Clinical Seminars on Emergency Medicine — Sponsored by the Medical College of Ohio:

May 1 — at Holiday Inn, Napoleon, 4:00-9:00 p.m., **Regional Enteritis/Ulcerative Colitis.**

May 9 — at Blanchard Valley Hospital, Findlay, 1:00-5:00 p.m., **Poisonings.**

May 29 — at Flower Hospital, Toledo; 4:00-9:00 p.m., **Acute Postoperative Surgical Emergency.**

Educational Opportunities in Ohio — *Continued*

May (Continued)

Fourth Annual Radiological Seminar — Veterans Administration Center, 4100 W. Third St., Dayton; May 29, from 8:30 a.m. to 4:15 p.m.; contact: Emil Gutman, M.D., Chief, Radiology Service, Veterans Administration Center, Dayton 45428.

June

University of Cincinnati College of Medicine (CONMED); Contact CONMED, 114 Medical College Bldg., Eden and Bethesda Aves., Cincinnati 45219:

Renal Disease Symposium — At Shrine Burns Institute, June 6.

Diagnostic Roentgenology — 16th Annual Refresher Course sponsored by the Radiology Department under direction of Dr. Benjamin Felson, June 10-14.

Medical Economics Seminar Combined with a Rhine River Cruise — Sponsored by the Medi-Club of the Academy of Medicine of Cincinnati, June 4-12.

Clinical Seminars on Emergency Medicine — Sponsored by the Medical College of Ohio:
June 5 — at Hardin Memorial Hospital, Kenton; 4:00-9:00 p.m.; tentative topic, **Surgical Emergency.**
June 11 — at Fisher-Titus Hospital, Norwalk; 4:00-9:00 p.m., **Burns.**

Seminars on Fundamentals of Surgery — Sponsored by the Medical College of Ohio at Toledo; Saturdays, 10:00 a.m. to noon; Room G-1, MCO. **Trauma,** June 1, 8, 15. For the June 8 seminar, visiting professor will be LaSalle D. Leffall, M.D., Howard University, whose topic will be **Abdominal Trauma.**

July

Association of Physicians of the State of Ohio —Quarterly meeting and program, July 12, Massillon State Hospital; contact Virginia S. Edwards, M.D., Secretary-Treasurer, 347 Lexington Ave., Mansfield 44907.

August

Ohio Academy of Family Physicians Annual Scientific Assembly—Cleveland Plaza Hotel, August 8-11; contact Mrs. Florence Landis, Executive Director, Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214.

Third Teaching Skills Workshop, sponsored by the OAFP at the Imperial House North, Morse Road at I-71, Columbus, Sept. 27-28; contact Mrs. Florence Landis, Executive Director, Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214.

September

Pediatrics and the Practicing Physician — Symposium sponsored by the Medical College of Ohio at Toledo and the Toledo Pediatric Society, Sept. 20-22, at Sheraton Westgate, Toledo. For additional information, write: Howard S. Madigan, M.D., MCO, P. O. Box 6190, Toledo 43614.

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In This Issue:

The Brown Pharmaceutical Co., Inc. 308, 339, 344

Burroughs Wellcome Co. 297

Capital Financial Services 339

Dorsey Laboratories, Div. of Sandoz-Wander, Inc. 333, 337

Flint Laboratories, Div. of Travenol Lab., Inc. 330

Lilly, Eli and Company 312

McNeil Laboratories, Inc. 327

Mead Johnson Laboratories 295

The Medical Protective Co. 311

Ohio Medical Indemnity 291

Pharmaceutical Manufacturers Association 300-301

Robins, A.H., Company 309-310

Roche Laboratories, Div. of Hoffman-LaRoche Inc. ...Inside Front Cover, page 289, 298-299, Inside Back Cover and Back Cover

William H. Rorer, Inc. 305

Schmid Laboratories 302-303

G.D. Searle & Co. 328-329

The Upjohn Company 306-307

Wendt-Bristol Co. 293

Warner/Chilcott 335

Windsor Hospital 296

Wolman Insurance Agency, Inc. 294

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.



Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

VOLUME 70 JUNE 1974 NUMBER 6

THE FRANCIS A. COUNTWAY
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BOSTON
JUN 19 1974

Original Articles

Early Diagnosis and Management of Acoustic Neuromas. John M. Tew, Jr., M.D., Richard J. Wiet, M.D., and Frank H. Mayfield, M.D., Cincinnati 365

Sensitivity of Intermediate-Strength Purified Protein Derivatives in Active Tuberculosis. Comparison of Stabilized and Nonstabilized Preparations. Juan A. Simon, M.D., Dayton 368

Maternal Health in Ohio: Maternal Deaths Associated with Appendicitis. By the OSMA Committee on Maternal Health 377

Your State Society at Work

Officers and Delegates Elected at the 1974 OSMA Annual Meeting 380

What the OSMA Council Did at Its April 6 Meeting 381

New Members of OSMA 384

Ribbon-Cutting Ceremonies Held for New OSMA Headquarters Building 390

Emergency Medical Services

Organization of Emergency Medical Services Councils 352

Medical College Activity

Medical College Building Cornerstone Laying Scheduled 356

Physician-Community Relations

Findlay Newspaper Reports Ten New Physicians Arriving 358

Your AMA at Work

AMA Annual Convention Set for June 22-27 in Chicago 362

AMA Grants to Medical Schools Reach New Peak 379

Public Health

Ohio Department of Health Reports on Gonorrhea Control, Reye's Syndrome, Certain Type of Food Poisoning 360

Woman's Auxiliary

Woman's Auxiliary Highlights 388

Other Features

Battelle Gets Contract to Study Anticancer Drugs 348

New Standards Scheduled for X-Ray Equipment 348

Obituaries 386

The Journal's Advertisers

The Journal's Advertisers in This Issue 396

Classified Advertisement 397

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Predominant psychoneurotic anxiety

Associated depressive symptoms

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard ant convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

responded to one

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According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



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in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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VOL. 70 JUNE, 1974 No. 6

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The Ohio State Medical Journal
17 South High Street, Suite 500
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Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

Subscription, $5.00 per year to nonmembers; single copy, 50 cents (outside Continental U.S., $6.50 and 65 cents).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertiser must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

Battelle Gets Contract To Study Anticancer Drugs

A prime contract for evaluating the safety and side effects of potential new anticancer drugs has been awarded by the National Cancer Institute to Battelle Memorial Institute's Columbus Laboratories.

In announcing the $3,794,147 two-year contract, Dr. Frank J. Rauscher, Jr., Director of the National Cancer Program, National Cancer Institute, noted that Battelle, as prime contractor, will be responsible for day-to-day management of the NCI toxicology program.

In their management and research activities, Battelle-Columbus scientists will work closely with NCI's Laboratory of Toxicology, which will monitor the contractor's performance and continue to be responsible for critical decisions. The program will be managed by Battelle-Columbus from its toxicology program office in McLean, Virginia.

Under terms of the contract, Battelle's Columbus Laboratories will establish a network of subcontracting laboratories, the number depending on the availability of new drugs ready for toxicology testing.

New Standards Scheduled for X-Ray Equipment

The Bureau of Radiological Health, a branch of the Federal Food and Drug Administration, has announced that a Federal standard for diagnostic x-ray equipment becomes effective August 1 of this year.

Now that terms of the standard are final, the FDA is sponsoring a number of regional workshops to explain these standards. These seminars are primarily for manufacturers and assemblers, but users are also affected.

Under the standard, x-ray manufacturers are responsible for producing equipment and components that perform according to requirements. The assembler's primary responsibility is to install the system according to the manufacturer's specifications. The assembler must certify that conditions have been met by filing specialized forms with the FDA's Bureau of Radiological Health, the State Radiation Control Agency (under the Ohio Department of Health), and the purchaser.

Radiation control officer for Region V which includes Ohio is Richard H. Cooke, Room A-1945, 175 West Jackson Blvd., Chicago, Illinois 60604.

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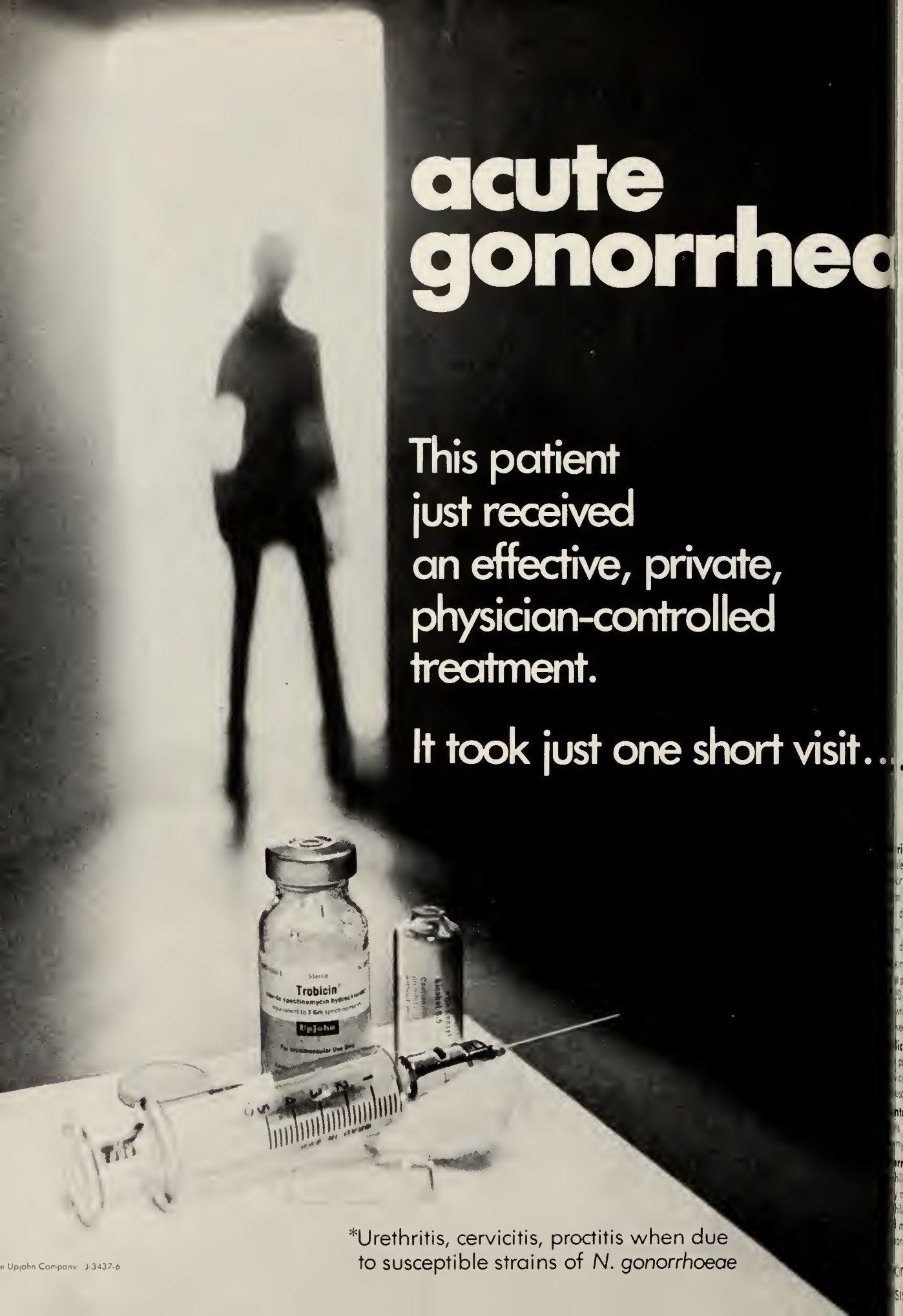
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Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
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minacyclitol antibiatic active in vitro against strains af *Neisseria gonorrhoeae* (MIC 7.5 mcg/ml). Definitive in vitro studies have n na crass resistance af *N. gonorrhoeae* een spectinamycin and penicillin.

cations: Acute ganarrheal urethritis practitis in the male and acute gonorrheal citis and proctitis in the female when due sceptible strains of *N. gonorrhoeae*.

traindications: Contraindicated in pa- previously faund hypersensitive to spec- nycin.

rnings: Nat indicated for the treatment of ilis. Antibiotics used to treat ganorrhea mask or delay the symptoms of incubating ilis. Patients shauld be carefully examined monthly serological follow-up for at least nths should be instituted if the diagnosis af syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

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Clinical effectiveness shauld be manitored to detect evidence af development of resistance by *N. gonorrhoeae*.

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or patients with gonorrheal proctitis and for patients in geographic areas where antibiotic sistance is known to be prevalent, initial treatment with 4 grams is preferred.

Organization of Emergency Medical Services Councils

By Robert S. Heidt, M.D., Cincinnati

THE EMERGENCE of coordinating councils for emergency medicine has been gradual but has now come into its own. This has been especially true in the past few years with governmental aid and insistence that a unified approach be made to the subject. Many large urban communities have already established groups that have coordinated the organization and agencies responsible for emergency care. Many have not. It is to those areas that this article is directed. The endeavor of establishing such a council is time-consuming and often frustrating, but your community will be a better place in which to live due to your efforts.

In caring for the needs of those injured in our community, it is necessary to realize that there are various categories which must be considered. Accidents involving one or two cars with four or five injured are usually well handled and do not tax the medical facilities nor cause transportation problems to any noticeable extent. They can and do constitute problems in themselves, however, with many ramifications, such as the manner in which the injured are transported to the hospital, the communication between the vehicle and the hospital, the possible utilization of medical helicopters, the proper standardization of the receiving emergency facility. All must be considered in these smaller groups.

Plans for Expansion

As the numbers increase in any specific accident, so do the logistic problems in caring for these patients. This is compounded markedly as the numbers enter into the hundreds as is seen in such catastrophes as tornadoes, hurricanes, and the like. It is impossible to wait until the accident or disaster occurs before adequate preparations are made. These must be coordinated plans that will utilize all facilities to their maximum benefit to give prompt and effective services to all injured. This involves a considerable list of agencies both civil and government, institutions and personnel in general.

Along these lines it is imperative that plans be arranged that are workable in all phases and in all types of disasters and emergencies. It is extremely rare that a community would be hit with a catastrophe involving hundreds of casualties but, in any case, it is possible. Any guidance of planning must be directed to the premise that a plan, to be workable, must be worked, and worked daily. This means that the same basic mode of action handled by the community for smaller accidents and emergencies, could and should be capable of enlarging in scope on a moment's notice to bring into operation a large spectrum of backup personnel, equipment, and prepared order of operation. All types of contingencies must be considered, but all must likewise be focused down to the everyday operation of the medical community. This would imply close relationship between governmental agencies, lifesquads, hospital emergency facilities, medical personnel, Red Cross, and agencies like Civil Defense.

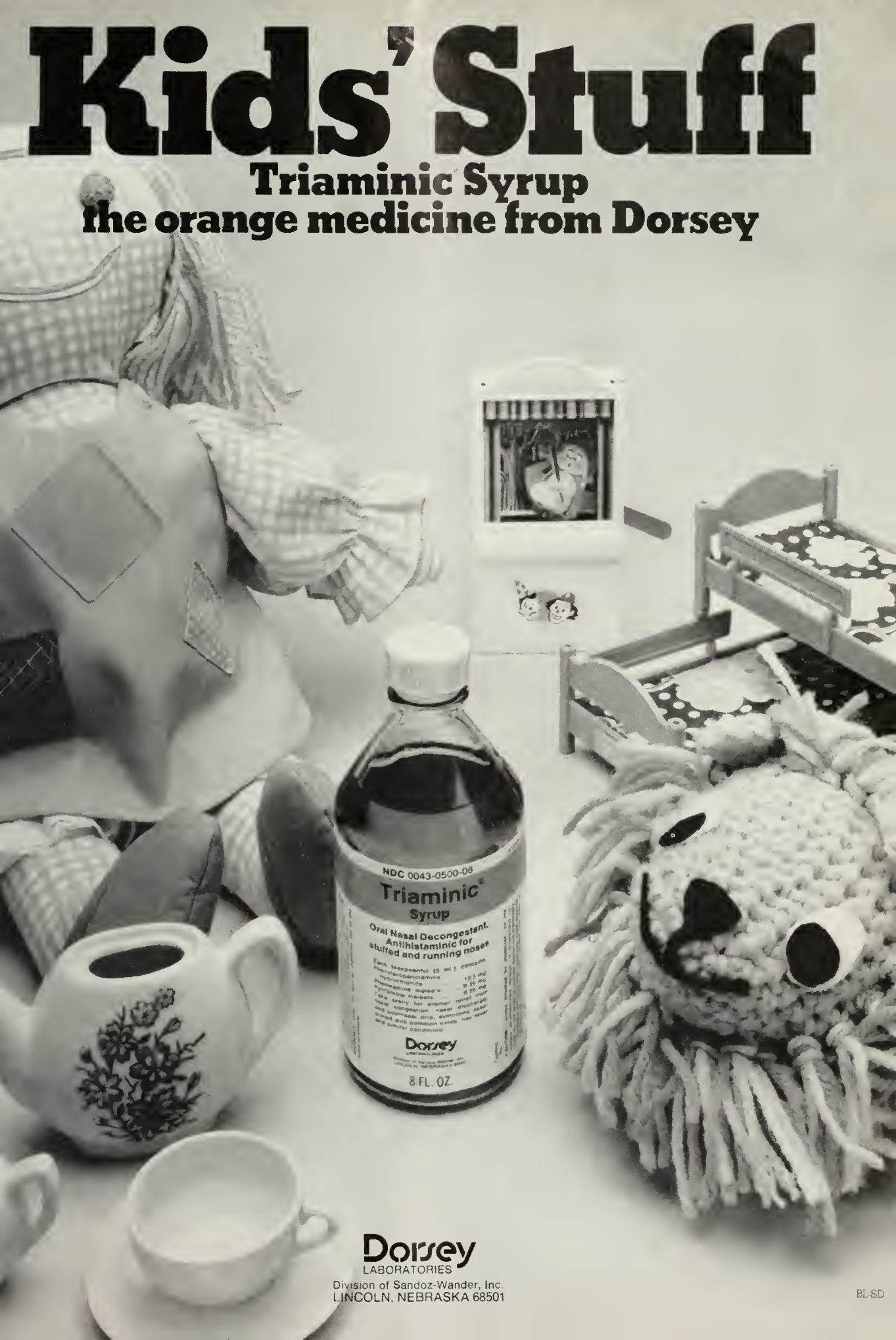
Organization in Cincinnati

It was interesting to note that when Cincinnati first started organizing for disaster preparedness over ten years ago, we encountered a very interesting paradox. It became apparent in our community that there were many groups who felt that they were responsible in the event of a disaster for some specific action. When these were called together in a central community meeting, all felt that their specific part of the disaster was well covered and had been organized well with plans. However, on close investigation it was found that the individual plans of the Police Department, Fire Department, Red Cross, Civil Defense, county medical societies, hospitals, and lifesquads all overlapped and intermingled. There were, none the less, large gaps in the entire process. These were primarily because of the fact that the individual groups in themselves had taken for granted that the other would assume certain responsibilities for caring for one specific phase of the emer-

Dr. Heidt is a practicing orthopaedic surgeon in Cincinnati and is chairman of the OSMA Committee on Emergency and Disaster Medical Care.

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gency and had left this area completely uncovered. It was also apparent that the various groups were also reduplicating themselves in coverage of some of the same phases so that in the event of an actual problem that there would be confusion because of several groups handling the same aspect of the problem in different ways. It likewise became very clear that in the field this would result in considerable confusion with the people involved, both rescuer and rescued, alike. It was also clear that, with a coordinated effort, the task of all personnel involved would be much simpler. Their segment of responsibility would be so delineated that it could be enlarged upon; whereas, they could ignore other phases with peace of mind knowing that these were being handled by competent groups. Of course, it presupposed that the groups would meet at frequent intervals to discuss various problems. It also presupposed that there would be practices to see if the actual plans would work in a coordinated program.

The Emergency Council

This led to the development of an emergency council which, in the Cincinnati area, was called the Hamilton County Disaster Planning and Coordinating Council. Its birth was delayed by numerous problems in establishing liaison between the various groups. The Cincinnati Academy of Medicine took the lead in organization chiefly because of the neutrality that the physician could offer to such groups.

It started with a small group of interested men from various organizations including the Red Cross, Civil Defense, Hospital Council as well as the physician. There were no plans to any extent to follow in those days. It was by trial and error. New groups were included in the main planning body. Various team approaches were tried, and failed. Numerous alerts were practiced, and found to be inadequate. The final working Council, as it exists today, was the result of much heartache, headache and compromise. Much of what was learned is included here.

These groups have a high degree of pride in their organizations and justifiably so. They have put many years in their effort to make a well organized team. Much of this time is on a voluntary basis. Their interests, support, and continued enthusiasm must be recognized and every action taken to insure that it continue and be encouraged.

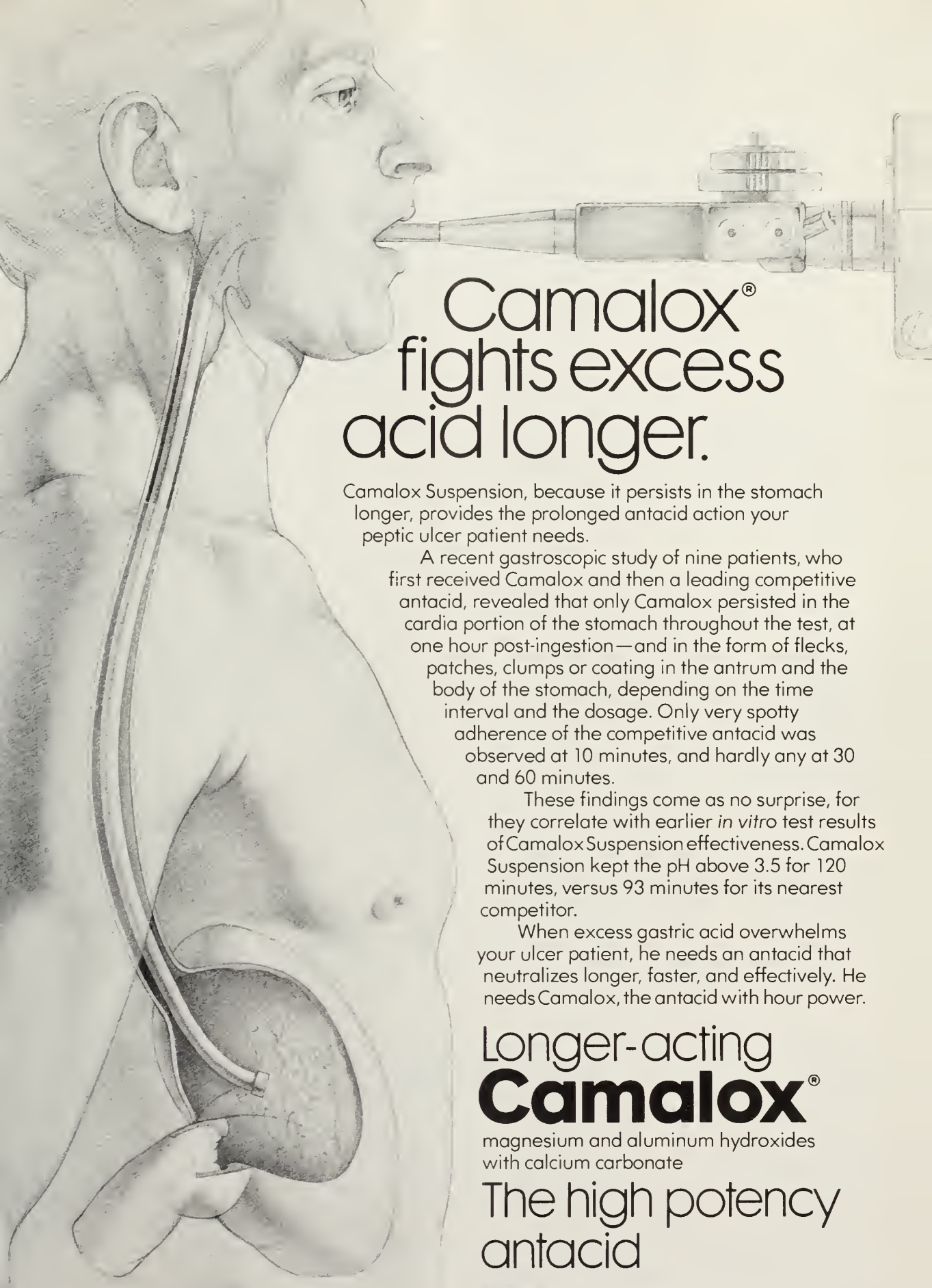
Here lies a crucial factor in organizations of these councils, in that a well-respected independent organizer must be found that could be related to, by all the existing groups, without fear of encroachment, in any respect, upon their own individualities. It seemed that this lies mainly with the physician representing the local medical society.

All Relevant Groups

In formulating an emergency group, it is extremely important to have representation from all factors. The local, city and county governments are extremely important and cannot be excluded. The Police and Fire Departments must all be represented. If there are county societies for the Police and Fire Departments, representation from these is mandatory. Lifesquads almost invariably have central groups and these likewise must be represented. Governmental agencies with city councils and representation from the smaller governmental agencies in the county must likewise be included. Red Cross representation is a must, since it can supply considerable backup facilities and excellent material and manpower, in the event of large catastrophes. Hospital councils or associations must likewise be represented to give impetus to coordinated activities from the hospitals.

It is important to keep the council relatively small with only one representative from the various agencies noted previously, since too large a group prohibits individual vocalization of various problems, fears and complaints. It is important that each of the groups have a definite say in what is going on because each is important in its own phase of the program. With the all-inclusive structure, it would seem that it would be a foregoing conclusion that all would wish to join. In general, you will find this not to be the case. It will take some salesmanship to show the various groups that coordination of policy will be to their best interest and they will not be over-shadowed by the magnitude of the group itself and that their organization will still work independent, but with a coordinated purpose.

Once the group is established many problems become apparent immediately. Mainly, such things as communication. It is found to be essential that a coordinated, integrated communications system is imperative to the success of the emergency endeavor of any magnitude. This means a communications system that will include the emergency departments of all hospitals with inter-communication with the lifesquads and with the Police and Fire Departments. This should be rather broad in scope and preferably with a coding mechanism, so that agencies and institutions can be called individually on a day-to-day basis without the necessity of opening the net to all, but with the capacity of having a general disaster provision so that all can be on at the same time. This radio network can be obtained on a private basis, through the industries in the locality. In fact, a large jet engine company donated the Hamilton County equipment. Backup men work by Red Cross and by the radio hams is extremely valuable. The Red Cross has an elab-



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These findings come as no surprise, for they correlate with earlier *in vitro* test results of Camalox Suspension effectiveness. Camalox Suspension kept the pH above 3.5 for 120 minutes, versus 93 minutes for its nearest competitor.

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orate system in many areas, and has proved its value on many occasions.

Practice Runs

Practices, to see if all agencies, institutions and personnel are performing their tasks adequately, are a necessity. At first, these need to be held often, but later annual checks are sufficient. Scope and nature is variable. It has been found that using actual victims made up to appear as specific injuries are more easily handled. The Mortuary College of the University of Cincinnati has done an excellent job for us in the past and are well-versed on this sort of thing.

Governmental health planning agencies must be taken into consideration. In the past year these are turning their direction to development of medical resources along the line of emergencies and disaster care. It is through these agencies that financing for various endeavors can be accomplished. It would seem that it would be difficult for these agencies in themselves to compile such councils with ease, although this is not beyond the realm of possibility. Their task, however, would be facilitated greatly by the development of councils in the manner noted above and financed through their endeavors.

The size of the community, the number of hospitals, lifesquads, and medical personnel will affect the need of the council. Smaller councils will of necessity rely upon larger areas for support in larger or more complicated emergencies. State emergency organizations will be of help in organizing backup support for smaller communities but the need for local council formation still exists and is imperative for a smooth-running, efficient operation for the emergency needs for our fellow men.

Cincinnati Medical College Cornerstone Laying Scheduled

A feature of this year's University of Cincinnati College of Medicine alumnal reunion on June 8 is the scheduled laying of the cornerstone for the new Medical Sciences Building. The new building in the Medical Center complex will be Medical College's home beginning this fall. Scheduled time for the cornerstone ceremony is 1:30 p.m.

Dr. Stanley B. Troup, who will become vice-president of the university and director of the Medical Center on July 1, will be present for the alumnal day activities, and will be officially introduced at a banquet in the Netherland Hilton Hotel that evening.

Dr. Gustav Eckstein, professor emeritus of physiology, is scheduled to read the remarks that will be placed in the cornerstone. Also taking part in affairs of the day are Dr. Robert E. Krone, alumnal association president, and Dr. Taylor Asbury, president-elect.

The morning program is scheduled in the Shriners Burns Institute.

NEW! Patient Therapy Packs

Because many patients tend to stop treatment prematurely, the full course of b.i.d. therapy is now specially packaged to encourage patients to complete the full course of therapy.

CANDEPTIN Vaginal Ointment Therapy Pack—two 75 gm. tubes
CANDEPTIN Vagelettes Therapy Pack—28 vaginal capsules
CANDEPTIN Vaginal Tablet Therapy Pack—28 vaginal tablets

Brief Summary

Description: CANDEPTIN (Candicidin) Vaginal Ointment contains a dispersion of Candicidin powder equivalent to 0.6 mg. per gm. or 0.06% Candicidin activity in U.S.P. petrolatum. 3 mg. of Candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain Candicidin powder equivalent to 3 mg. (0.3%) Candicidin activity dispersed in starch, lactose and magnesium stearate.

CANDEPTIN VAGELETTES Vaginal Capsules contain 3 mg. of Candicidin activity dispersed in 5 gm. U.S.P. petrolatum.

Action: CANDEPTIN Vaginal Ointment, Vaginal Tablets, and VAGELETTES Vaginal Capsules possess anti-monilial activity.

Indications: Vaginitis due to *Candida albicans* and other *Candida* species.

Contraindications: Contraindicated for patients known to be sensitive to any of its components. During pregnancy manual Tablet or VAGELETTES Capsule insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.

Caution: During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.

Adverse Reaction: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment, Vaginal Tablets or VAGELETTES Vaginal Capsules have been extremely rare.

Dosage: One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet or one VAGELETTES Vaginal Capsule is inserted high in the vagina twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.

Available Dosage Forms: CANDEPTIN Vaginal Ointment is supplied in a Patient Therapy Pack, containing two 75 gm. tubes with two applicators for the full course of treatment. CANDEPTIN Vaginal Tablets are packaged in boxes of 28, in foil with inserter—enough for a full course of treatment. CANDEPTIN Vagelettes Vaginal Capsules are packaged in a Patient Therapy Pack, containing 28 CANDEPTIN Vagelettes Vaginal Capsules (2 boxes of 14), for the full course of treatment. Store under refrigeration to insure full potency.

Federal law prohibits dispensing without prescription.

References:

1. Melges, F. J.: Obstet. Gynecol. *24*:921, Dec. 1964. **2.** Cameron, P. F.: Practitioner *202*:695, May 1969. **3.** Olsen, J. R.: Journal-Lancet *85*: 287, July 1965. **4.** Giorlando, S. W.: OB/GYN Digest *13*:32, Sept. 1971. **5.** Decker, A.: Case Reports on file, Medical Department, Julius Schmid. **6.** Friedel, H. J.: Md. State Med. J. *15*:36, Feb. 1966. **7.** Roberts, C. L. and Sullivan, J. J.: Calif. Med. *103*:109, Aug. 1965. **8.** Giorlando, S. W., Torres, J. F. and Muscillo, G.: Am. J. Obstet. Gynecol. *90*:370, Oct. 1, 1964. **9.** Abruzzi, W. A.: Western Med. *5*:62, Feb. 1964.

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Nine In A Package

Findlay Gains 10 Physicians

Quoted from The Republican-Courier, Findlay, March 1, 1974
By Republican-Courier Staff Writer Dave Dudley

Thanks to a rather unusual package deal, Blanchard Valley Hospital will gain 10 new doctors over the next several years, and hospital officials are literally beaming over the hospital's good fortune.

Official announcement that a group of nine doctors, classmates at Ohio State University, will be coming to Findlay was made at Blanchard Valley Hospital's annual meeting Thursday evening.

Three of the nine, Dr. William H. Kose, Dr. Thomas L. Mount and Dr. Alan T. Tong, attended the annual meeting.

In addition, Dr. William Alcott, a graduate of Western Reserve University and a resident at Riverside Hospital, will be coming to the hospital this July, bringing the total number of new doctors to 10. Dr. Alcott is a specialist in orthopedic surgery.

Dr. Kose said the group began thinking about setting up a "corporation practice" about three years ago, but that they "never figured we'd all go to the same place."

"We're not the first group to try this, but it is a little unusual," Dr. Kose said. "We think it's rather important to have good people to work with."

Dr. Kose said the group had visited a number of other communities, and said they selected Findlay mainly because of the acceptance they received from physicians in the community.

Dr. Mount agreed: "Feeling we would be welcome here meant a lot to us."

He added that with their ties at Riverside Hospital in Columbus, where they are serving their residencies, and with Ohio State University, they hope to recruit more talent with various specialties for Blanchard Valley.

The nine are presently completing their residencies in the Columbus hospital, and the first will be arriving in July. In July of 1975 five more will be coming to Findlay, and the remaining three will arrive the next year.

Dr. LeRoy L. Schroeder, one of the nine, originally contacted the hospital in June 1972, indicating that he and his colleagues were interested in working together in a smaller community, and that Findlay was being considered.

Two of the physicians, Dr. Tong and Dr. Richard H. Deerhake, are natives of Findlay.

In 1972 the hospital hosted a dinner in Columbus for the doctors and a special "Findlay weekend" to discuss the possibility of their coming to Findlay. The following January, however, the nine made a tentative decision to practice in Cambridge.

"But I understand the reception by the entire community of Cambridge was not what they would liked to have seen," William Ruse, Blanchard Valley Hospital administrator said.

Ruse said besides the reception they received here, the plans for a new medical office complex near the hospital played a part in their decision.

The new doctors will eventually have offices in that complex, which is scheduled to begin in June.

Ruse also attributes the success in bringing the nine to Findlay to the combined efforts of the hospital staff, the Hancock County Medical Society Physicians Recruitment Committee and the Citizens' Physician Recruitment Committee.

The citizens' committee first met in September 1972, and determined at that time that although medical needs in the community were being met, many physicians were carrying an excessive work load.

To illustrate the need for new doctors in the community, Ruse pointed out that there are presently 47 physicians at Blanchard Valley Hospital, two less than there were 10 years ago. By the same token, the population of Hancock County has grown from 56,000 to over 62,000 persons over the same period.

And while the American Medical Association recommends one physician for every 1,000 people in the county, in 1972 there was one for every 1,325. In 1963 that figure was one for every 1,145 persons.

"With these nine physicians we will have met most of the needs at the present time," Ruse said.

Ruse also mentioned that there is a need for specialists in internal medicine, obstetrics and gynecology, and orthopedic surgery.

Of the nine new doctors, five are specialists in internal medicine, three in obstetrics and gynecology, and one in orthopedic surgery.

The first of the group to arrive this July will be Dr. William H. Kose, a specialist in internal medicine.

In July 1975 five more will arrive: Dr. Thomas L. Mount, with a specialty in internal medicine and subspecialty in neurology; Dr. Ronald A. Pohlmeyer, specialty in internal medicine, subspecialty in hematology; Dr. Alan T. Tong, Dr. Joseph Weingates and Dr. Emil C. Zeigler, all three with specialties in obstretics and subspecialties in gynecology.

Arriving in July 1976 will be Dr. Richard H. Deerhake, specialty in orthopedic surgery; Dr. LeRoy L. Schroeder, specialty in internal medicine, subspecialty in endocrinology; and Dr. Michael W. Lindamood, specialty in internal medicine, subspecialty in rheumatology.

* * *

OSMJ Editor's Note: Drs. Kose and Tong are former OSMA Family Practice Scholarship recipients, both 1967-1970.

The post-T & A patient:
another type for Tylenol
(acetaminophen)



When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.[1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding....Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Reuter, S. H., and Montgomery, W. W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J. B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A. D., and Pearson, H. A.: J. Pediat. *78*:558-560 (March) 1971.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

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Community Health News

Ohio Department of Health

John H. Ackerman, M.D., Deputy Director

1. Gonorrhea Control

Through the combined efforts of private and public medicine, progress is being made in controlling gonorrhea. Of the 9,286 gonorrhea infections reported to the Ohio Department of Health during the quarter ending March 31, 1974, 4,536 were males and 4,750 were females. For the first time since this data has been collected, males were **exceeded** by females with a ratio of 1:1.04. This represents substantial progress when compared with the 2:1 ratio of two years ago and reflects a reduction in the reservoir of females with asymptomatic gonorrhea. Gonorrhea culturing of females of child-bearing age played a major role in the above with over 122,000 cultured as opposed to 94,000 during the previous quarter. Of the 122,000 cultured, 4,357 were diagnosed as having gonorrhea and were treated.

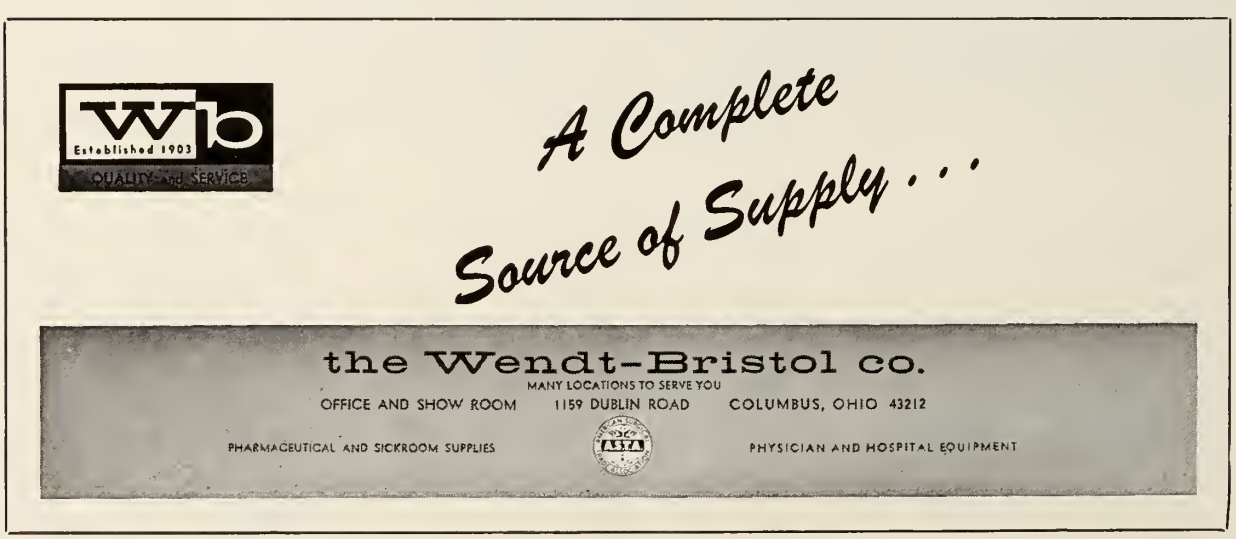
2. Reye's Syndrome

There were an unusually large number of cases of Reye's Syndrome during the first three months of 1974. Forty-three cases have been reported; the bulk of the cases occurred in the southwest district (25). Hamilton County led with 17 cases; Cuyahoga had five cases; Montgomery, Lucas, Lake, Clark, Franklin, and Butler recorded two cases each. One case was reported from Williams, Wood, Sandusky, Knox, Licking, Guernsey, Vinton, Darke, and Preble Counties. The case mortality rate in the past was about 50 percent, however, for this three-month period only four deaths were recorded from the 43 cases reported. Most cases occurred shortly after the child had a non-specific upper respiratory infection, but a few followed a chickenpox infection. It appears that this recent outbreak has ended, since no new cases have been reported since the first week in April.

3. Clostridium Perfringens Food Poisoning

On March 31, 1974, 435 veterinary medical students from 17 veterinary colleges attended a prime rib banquet in Columbus. The next day, 75 percent of students at the meal had onset of gastroenteritis. Median incubation period was 11 hours. The illness lasted less than two days in almost all cases. Symptoms were diarrhea (100%), cramps (95%), and nausea (39%). Initial laboratory studies showed elevated bacterial counts of *Clostridium perfringens* in the prime rib and in stools of affected persons. Incubation period, duration, and symptoms were typical for *C. perfringens* food poisoning.

C. perfringens food poisoning results from ingestion of food contaminated by large numbers of *C. perfringens* vegetative cells. The majority of outbreaks are connected with consumption of cooked meat or poultry that has been held at improper temperatures for several hours between cooking and serving.



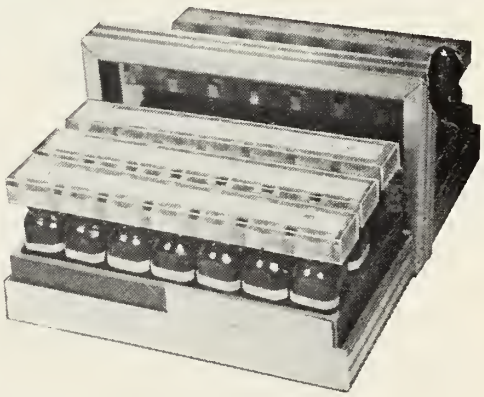
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AMA's Annual Convention Set June 22-27 in Chicago

Hundreds of Ohio physicians are expected to attend the 123rd annual convention of the American Medical Association to be held June 22-27 in Chicago.

Some 9,000 physicians from throughout the nation are expected to attend. With physicians' guests, medical students, nurses, allied medical professionals and others, total attendance is expected to reach 20,000.

Dealing with health issues and medical knowledge from the viewpoint of the practicing physician is the continuing aim of this year's scientific program.

A new feature of the 1974 convention will be a series of fireside forums. They will be informal evening presentations at the downtown Hyatt House Hotel in which participants will visit one of of six Chicago medical schools via half-hour videotapes made by the faculty working with equipment and patients. The faculty which assisted in the tapings will be present to conduct informal discussions.

Preliminary program for the convention was published in the April 15 issue of the *Journal of the American Medical Association.*

A total of 54 scientific sessions are scheduled, in addition to 36 postgraduate courses. Eight postgraduate courses open the scientific program on Saturday, June 22, which runs through Wednesday, June 26. The business meeting of the AMA House of Delegates starts June 23 and is slated to end Thursday, June 27.

Besides the wide variety of special sessions, there will be an array of exhibits, both scientific and industrial, and the presentation of 30 medical films, including a special symposium on how physicians themselves can produce a medical movie.

Bulk of the scientific sessions will be held in McCormick Place, Chicago's lakefront convention center. The House of Delegates' sessions will be held in the Palmer House.

Among Exhibit Hall highlights at McCormick Place will be several new features, including the Journal of the AMA's filmed clinical pathological conferences, which will be shown for the first time. There will be a cardiopulmonary resuscitation exhibit and course in basic life support. The fresh tissue pathology exhibit will mark its 75th anniversary at an AMA scientific program.

In the postgraduate arena, seven courses will be conducted by the American Society of Clinical Pathologists, designed to assist the non-pathologist physician. Other courses include: life-saving measures for the critically injured; diagnosis and management of common kidney diseases; dermatology; urology; human sexuality; gynecology; drugs in the emergency room, and sports medicine and athletic injuries.

A number of new scientific programs will join traditional features on the scientific convention program. A highlight will be a study of the practitioner's approach to angina. An all-day session on this topic will be presented. A special half-day symposium will be on office treatment of high blood pressure. Another half-day session will present data on how physicians can help obese patients to control their weight.

Malcolm Todd, M.D., of Long Beach, Calif., will take office during the convention as new president of AMA, succeeding Russell B. Roth, M.D., of Erie, Pa. A new president-elect will be named by the House of Delegates.

The annual program on medicine and religion will be held on Sunday, June 23.

A one-day workshop on writing for scientific journals, co-sponsored by the American Medical Writers Association and the AMA Council on Scientific Assembly, will be held Saturday, June 22, in McCormick Place.

Must vasodilators and therapy for other diseases come into conflict?



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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Early Diagnosis and Management of Acoustic Neuromas

John M. Tew, Jr., M.D.
Richard J. Wiet, M.D.
Frank H. Mayfield, M.D.

HARVEY CUSHING PIONEERED the diagnosis and treatment of acoustic tumors. In his work, *Tumors of the Nervus Acusticus and Syndrome of the Cerebello-pontine Angle,* (1917), he wrote: "It would be ideal could the lesion be recognized when the acusticus was alone involved."[1] Cushing implied the importance of the early diagnosis of the acoustic tumors when they are small, permitting surgical removal with minimal neurologic deficit. In this report, it is the intention of the authors to review the natural history, diagnostic technics, and surgical management of acoustic tumors for the clinician.

The acoustic tumor is the most frequent tumor arising from a cranial nerve; it accounts for 10 to 20 percent of all intracranial tumors and is second only to gliomas and meningiomas in frequency. The tumors occur with equal frequency in the sexes and have a peak incidence in the fourth and fifth decade.

The acoustic neuroma originates as a result of neoplasia of Schwann cells on the vestibular portion of the eighth cranial nerve within the auditory canal. Although called by some a "Schwanoma,"[2] the term neurinoma or neuroma, has prevailed. It is a benign tumor and is curable by surgical extirpation.

Grossly, the tumor begins within the internal auditory meatus and remains attached by a stalk. Should its presence go unnoticed, the tumor mass expands into the angle formed by the cerebellum and pons. Prior to this expansion, its presence may be recognized by symptoms related solely to eighth nerve compression, namely, hearing loss, tinnitus, and dizziness. These tumors are small, generally less than 8 mm in diameter, and are confined to the internal auditory canal (Stage I on the table).

Dr. Tew is Assistant Director, Neurosurgical Training Program, Good Samaritan Hospital; Instructor in Surgery, Division of Neurosurgery, University of Cincinnati College of Medicine.

Dr. Wiet is Junior Resident Otolaryngology, Cincinnati General Hospital; and Adjunct Instructor of Speech and Hearing, Graduate School, University of Cincinnati.

Dr. Mayfield is Director, Department of Neurosurgery, Christ Hospital; Chairman, Section of Neurosurgery, Good Samaritan Hospital; and Clinical Professor of Surgery (Neurosurgery), University of Cincinnati College of Medicine.

Submitted September 17, 1973.

Diagnosis

The recommended initial clinical evaluation should include, first, otoscopic examination to exclude middle or external ear disease; second, a systematic neurologic examination with emphasis on cranial nerve function. Hearing loss is the initial symptom in more than 50 percent of the cases;[3] it is described as typically unilateral and progressive in nature. The deafness is noted in ordinary conversation when the patient "favors" one ear, or has difficulty with telephone conversation.

A reasonable estimate of hearing deficit may be done in the office with the "wrist watch test," or the whispered voice test, but a more quantitative determination may be obtained by tuning-fork tests or referral for audiologic examination.

Tinnitus, another early symptom of eighth nerve compression, is described as a hissing, ringing, or roaring sound. It may be continuous or intermittent in nature, and its presence is usually elicited only by careful questioning.

The vestibular branch of the auditory nerve plays an important part in body positioning and balance. Compression of this may cause dizziness, unsteadiness, or vertigo. Dizziness is, however, an initial symptom in only 10 percent of the patients with acoustic tumors.[3] Vertigo is much more suggestive of Meniere's disease, which is characterized by fluctuating hearing loss, roaring tinnitus, and spontaneous vertigo. The latter frequently is accompanied by nausea and vomiting.

Vestibular function may be tested in the office by irrigation of the external auditory canal with cold water. With the patient's head inclined 60°, one auditory canal is irrigated with 5 cc of ice water. Coarse ocular nystagmus in all fields of gaze with the fast phase directed away from the

stimulus, is the normal response. Diminished or absence of nystagmus indicates a nonfunctioning labyrinth, a frequent finding in patients with acoustic neuromas. Normal or exaggerated response may be seen in patients with Meniere's disease.

Cranial nerves in proximity to the eighth nerve are affected only when the tumor expands into the cerebellopontine angle. These tumors are classed as medium size, or Stage II, approximately 2.0 to 3.0 cm in diameter. The seventh cranial nerve lies nearest to the eighth in the internal auditory canal; yet there is seldom any deficit of motor function even in large acoustic tumors. Facial nerve fibers carry motor, sensory, and parasympathetic function to the face. Simple tests of motor function include asking the patient to whistle, to open his eyes widely, or to show his teeth. Only very large acoustic tumors compress the seventh nerve sufficiently to produce facial weakness. A more common and earlier finding, however, is diminution in taste. Taste function may be tested by application of salt or sugar to the tongue. Diminished tearing, a parasympathetic function, may be recognized by the litmus paper test.

When the acoustic tumor advances to Stage II, the trigeminal nerve outside the internal auditory canal is the most common cranial nerve to become involved. Symptoms of numbness and paresthesias of the face indicate compression of the fifth nerve. A diminished corneal reflex is the earliest clinical finding suggesting this involvement.

Other cranial nerves are uncommonly involved with acoustic tumors. However, dysphagia and dysphonia indicate compression of the ninth and tenth nerves and may be seen occasionally in large Stage II or Stage III tumors.

Involvement of the brain stem and cerebellum is a late manifestation, indicating a Stage III tumor. The patient complains of neck pain, headache, or visual changes as a result of increased intracranial pressure. Papilledema and hydrocephalus, secondary to obstruction of the aqueduct and fourth ventricle are late signs indicating a large tumor and impending death.

Upon completion of the clinical examination, certain diagnostic tests are necessary for confirmation of acoustic tumors. Special radiographs of the petrous bones may show enlargement or erosion of the internal auditory meatus on the side of the tumor. Posterior fossa myelography may be necessary to outline a mass in the cerebellopontine angle. Radiographic contrast studies not only confirm but may indicate the size of the tumor mass.[4] Cerebrospinal fluid obtained in conjunction with myelography shows protein elevation in 70 percent of patients.

Audiologic testing is another adjunct to clinical evaluation. A battery of tests has been devised by otologists to aid in the distinction between disorders of hearing due to cochlear or to nerve lesions.[5] If these studies indicate a neural type of

Clinical Tests for Acoustic Nerve Tumors*

Nerve	Function	Test	Finding	
VIII	Hearing	1. Tuning fork	Hearing loss	
		2. Speech discrimination	Diminished	
		3. Audiometry	Sensory — neural hearing loss	Stage I
	Balance	Rhomberg	Usually normal	
		Caloric test	Hypoactive labyrinth	
VII	Facial motion	Observation	Usually normal	
	Taste	Sugar tip tongue	Frequently decreased	
	Tearing	Litmus paper	Decreased	Stage II
V	Facial sensation	Pin prick	May be decreased about lips and cheeks	
	Corneal sensation	Corneal reflex	Frequently decreased	
IX, X	Swallowing	Gag reflex	Decreased	
	Speech	Observation	Dysphonia or dysarthria	Stage III
Cerebellum	Gait	Observation	Ataxia	
	Retina	Ophthalmoscopy	Papilledema	
Spinal fluid	Protein pressure		Normal or increased	
X-ray	Laminograms of petrous bone		Enlarged internal auditory meatus	
	Pantopaque myelogram		Filling defect internal auditory meatus	

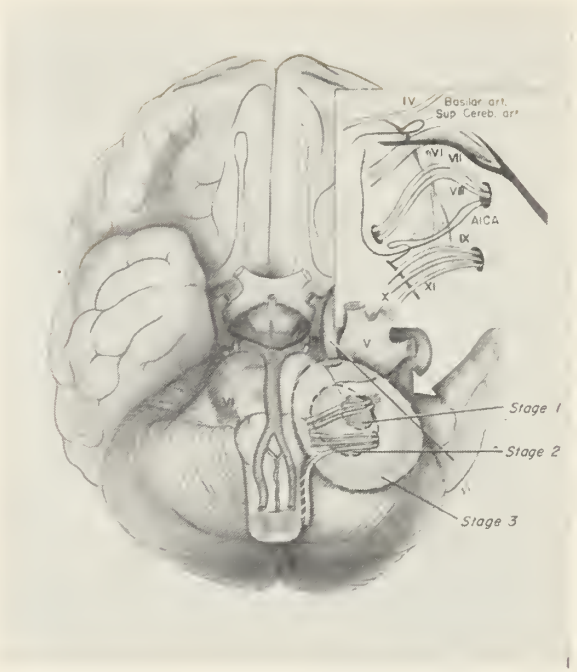
*Revised with permission from Burton J. Soboroff, M.D. and the *American Journal of Medical Sciences*.[12]

hearing loss, the suspicion of acoustic tumor is heightened.

Surgical Management

Early in the course of brain tumor surgery, Cushing set a precedent for removal of acoustic tumors.[1] For decades, his approach of intracapsular evacuation of the tumor through an occipital craniotomy was the definitive procedure for these tumors. Despite its low mortality, the Cushing technic was plagued by a high rate of recurrence. This factor influenced Dandy to introduce the concept of total tumor removal, which is practiced today.[6]

Presently, the surgical management of acoustic tumors generally depends on tumor size.[7-9] Stage I tumors may be removed by the temporal or occipital approach with the expectation of little or no morbidity. Sparing of the facial nerve can be expected and preservation of functioning hearing has been reported.[10] Unfortunately, when the tumors enlarge to Stage II or III, not only is preservation of nerve function uncertain but the risk to life is significant.[11] Yet, owing to the refinements of magnification with the surgical microscope and specialized instrumentation, the overall risks of total extirpation have been greatly reduced.



Pathologic stages of acoustic neuromas. Stage I: small tumor (intracanalicular) 2 to 8 mm; Stage II: medium tumor 0.8 to 3.0 cm; and Stage III: large tumor 2.5 cm or more.

Conclusion

Modern otologic and radiologic technology has advanced sufficiently to provide the means for an early and accurate diagnosis of acoustic neuroma. Yet, the goal, eradication of the tumor when small and easily removed, is achieved only if the clinician is aware of early clinical manifestations and establishes the diagnosis. Today's surgical advances permit total tumor removal with preservation of neurologic function provided the clinician makes the early diagnosis.

Summary

Modern otology and radiology provide the methods for accurate diagnosis of acoustic nerve tumors. Advances in surgical technic permit total tumor removal with preservation of normal neurologic function if the tumors are recognized during the early stages of growth (Stage I). Yet discovery of the lesion when small and easily removable depends on the suspicion and acumen of the primary clinician. Small tumors (Stage I) are confined to the internal auditory canal. Symptoms related to the eighth nerve compression and expansion into the cerebellopontine angle include tinnitus, deafness, and dizziness. Medium-size or Stage II tumors, up to 2.5 cm, may compress neighboring cranial nerves causing facial paresthesias. Late, Stage III, tumors compress lower cranial nerves and brain stem resulting in dysphagia, dysphonia, and ataxia. Treatment is surgical and a pleasing recovery can be expected, particularly in patients with small tumors.

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Sensitivity of Intermediate-Strength Purified Protein Derivative in Active Tuberculosis

Comparison of Stabilized and Nonstabilized Preparations

Juan A. Simon, M.D.

FOLLOWING THE REPORTS of Furcolow and associates[1] and Hewell and Suyemoto,[2] challenges have been directed toward the traditional concept that nearly all patients with active tuberculosis due to *Mycobacterium tuberculosis* will give positive reactions to the tuberculin test.

Kent and Schwartz[3] reported 12 patients with active pulmonary tuberculosis who had negative skin tests from PPD. Stead[4] has estimated that false-negative tests occur in 20 percent of newly admitted patients and 30 percent in the elderly, debilitated, and very ill patients. Grzybowski and Bates[5] found that 80.5 percent had negative or doubtful reactions to a lot of commercial PPD. Hughes and co-workers[6] revealed that 17 percent of patients with tuberculous peritonitis were negative on both first-strength and second-strength PPD skin tests. Zack and Fulkerson[7] in their series reported 9.2 false-negative to commercial PPD and 1.5 percent with the liquid stabilized preparation. More recently, Holden and associates[8] found 49 percent of negative reaction to commercial PPD with 10 percent of doubtful reactions, 34 percent negative, and 3 percent of doubtful reactions to PPD-S and 17 percent negative tests and 2 percent doubtful to stabilized PPD with Tween 80.

The present investigation was undertaken to evaluate the currently controversial issue on the sensitivity of the skin test (Mantoux) in active tuberculosis due to *M. tuberculosis*. Commercial PPD and stabilized PPD with Tween 80 were selected for use in the study. The former was chosen because of its high percentages of false-negative tests and the latter, because it has shown the least false-negative tests.

Materials and Methods

During the period of May 1972 until June 1973, one hundred patients were simultaneously skin tested (Mantoux) with commercial PPD* and with stabilized PPD.† Ninety of these subjects were patients from the Pulmonary Disease Section, Veterans Administration Center, Dayton, Ohio, and ten from the Stillwater Sanatorium, Dayton. All patients were shown to have active tuberculosis due to *M. tuberculosis* based on cultures in Lowenstein-Jansen media with the characteristic colonies lacking pigmentation and having a positive niacin test. Patients with Hodgkin's disease and atypical mycobacteria infections were excluded from the study. All were male adults except for one female patient. Seventy-three patients were white and 27 nonwhite. Their ages ranged from 22 to 85 years with an average of 52 years. Thirty patients had far-advanced pulmonary cavitary disease; nine moderately advanced cavitary disease; 30 far-advanced disease; 20 moderately advanced disease; and nine minimal disease. One had tuberculosis peritonitis and one had tuberculosis of the hip. The extent of the disease in the 98 patients with pulmonary tuberculosis was established in accordance with the Diagnostic Standards and Classifications of Tuberculosis.[9]

As recommended by the Committee on Diagnostic Skin Testing of the American Thoracic Society,[10] commercial PPD was administered to all patients in less than ten minutes after reconstitution.

The same physician injected both materials intracutaneously in the volar forearm, one in the right, the other in the left, using disposable tuberculin plastic syringes with 26 gauge 3/8 intradermal bevel.

The results were read at 48 hours by the physician and a well-trained nurse by the "ball-point pen" method (Fig. 1).[11] After palpation, a firm, smooth line is drawn with a ball-point pen toward

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Submitted November 26, 1973.

*5 TU-PPD-MSD (Merck Sharp & Dohme) lots 1064N, 1714N.

†5 TU-PPD-T stabilized with 0.0005 percent Tween 80, Connaught Lab, batch CT68, lots 2976-1, 12090-1.



FIG. 1. Demonstration of "ball-point pen" method.

the induration. The progress of the point of the pen ceases when it reaches the edge of the induration. The line of demarcation is easily identified in this manner. The shortest diameter of the induration is measured in millimeters.*

All anergic patients were retested with the same materials seven to ten weeks following the institution of antituberculous chemotherapy. These patients were not retested with second-strength PPD because positive reactions are frequently associated with infection by atypical mycobacteria.[12] However, use of second-strength PPD could be of value in areas where atypical organism infections are infrequent.[13]

Results

Ninety-three of the patients were found to be positive to both antigens and one had a positive reaction to stabilized PPD but a doubtful reaction to commercial PPD. Six patients had no reaction to either agent (Table 1).

The size of the induration[17] when compared, commercial PPD vs stabilized PPD, was statistically insignificant with a correlation factor of $r = +.84$ (Fig. 2).

When patients were grouped according to age, race, and extent of disease, no correlation could be made in regard to the size of the induration with either preparation.

Those patients with overwhelming debilitated disease who were initially nonreactive, were retested with both antigens seven to ten weeks after institution of antituberculous treatment (Table 2). Four of them showed positive reactions to both preparations greater than 10 mm induration. Two showed doubtful reactions to both antigens.

Discussion

It is known that sensitivity to PPD may wane or disappear with advancing age, in severe febrile illness, measles, other exanthema, and with live virus vaccinations. Anergy to PPD has also been recognized in sarcoidosis, Hodgkin's disease, overwhelming miliary or pulmonary tuberculosis, and during therapy with adrenalcorticoid hormones or immunosuppressive drugs.[9] On the other hand, false-positive reactions have occurred after blood transfusions to tuberculin-negative individuals from tuberculin-reactive donors and should be differentiated from the "booster" effect of previous tuberculin tests.[14]

All anergic patients in this study fell in the category of overwhelming disease since all other mechanisms were excluded.

That tuberculin adheres to glass and other materials was known as far back as 1911.[15] Their problem at that time was to find the best method of cleaning nondisposable syringes to avoid an increased accumulation of the material in further testing. A series of investigations by Waaler and associates,[16] Magnusson and co-workers,[17] and Landi, et al[18] resulted in the consensus that about 60 percent of the potency of tuberculin is lost after restoration of the product due to the

TABLE 1. Comparisons of Both Preparations*

Size	Commercial PPD (%)	Stabilized PPD (%)
0	6	6
0-4	—	—
5-9	1	—
10-14	29	14
15-19	43	39
20-24	16	29
25-29	4	5†
30-34	1	6
35-39	—	—
40-44	—	1
	100	100

*Reactions of 10 mm of duration or larger were read as positive; those from 5 to 9 doubtful; less than 5 negative; and 0 anergic.

* Notice that majority of reactions range between 10 mm to 25 mm of induration with either antigen.

† One blistered.

adsorption to the wall of the containers. This could be prevented with the addition of the detergent Tween 80 in a concentration of 0.0005 percent.[18]

The more recent, clinical trials of Wijsmuller and Termini[19] have shown that storage of a solution of commercial PPD for two weeks resulted in more than 50 percent loss of biologic activity. Prefilling of syringes with the two-week-old dilution caused further loss of activity.

The results of our investigation were similar to those reported by Edwards[12] in 2000 white patients who were from different areas of the United States, had bacteriologically confirmed diagnoses of clinical tuberculosis, and were tested with intermediate PPD-S. Ninety percent of these patients had positive reactions of 10 mm or more but 2 to 6 percent had no reactions at all. Similar response was also found in widely separated parts of the world despite differences in nutrition, race and other factors. Also, Kazemi[13] estimated that only about 5 percent of patients who had proven active tuberculosis at both the Massachusetts General Hospital and the Middlesex Tuberculosis Sanitorium had negative skin tests to intermediate PPD. Besides, Singh and associates[20] found that all of 47 patients with tuberculous peritonitis had positive reactions to first-strength PPD skin test.

Stead[4] found that 98 percent of patients reacted to intermediate PPD if testing was delayed until the patients were well nourished. When tested shortly after admission, 20 to 30 percent showed a negative skin test. While our investigation did not show as high a number of initial false-negative tests, the incidence of positive tests on retesting reaffirmed the relevance of Stead's observation. There are several explanations for this phenomenon. One is the "booster" effect of retesting[1] experimentally demonstrated by Shivpuri,[21] who found that repeated tuberculin tests using 100 TU-PPD or subcutaneous injections of 1250 TU-PPD induced delayed hypersensitivity reactions in previously infected but tuberculin-negative guinea pigs. Our patients were retested with only 5 TU-PPD which is probably too low a concentration to produce a booster effect. The most provocative explanation may be in the report by Nilsson,[22] who found that lymphocytes from tuberculin-positive individuals react differently from tuberculin-negative individuals when exposed in vitro to varying concentrations of PPD and DNA synthesis is studied by ^{14}C-thymidine uptake. Lymphocytes from skin-negative individuals did not react at lower PPD concentrations. Lymphocytes from skin-positive individuals reacted at the lowest concentrations and exhibited progressive increase in uptake of ^{14}C-thymidine up to 10 μg per ml. At that level, no further increase in activity was found in six cases but decreased reactivity was demonstrated in four cases. The decreased reactivity was immunologically specific because the same cells when retested reacted normally to a second antigen. He concluded that the findings may be related to lymphocyte populations with receptors having different affinity to the antigen. In the skin-negative individuals, mainly low affinity cells exist, which require high PPD concentrations for activation; in the positive individuals, high affinity cells predominate, which react at lower antigen concentrations and may become paralyzed at higher levels. He speculated that the anergy found in miliary tuberculosis may be due to such mechanism.

Our results support the classical experience that the vast majority of patients with active tuberculosis due to *M. tuberculosis* will respond with positive tests to either nonstabilized or stabilized preparations if the tests are performed and read properly by experienced persons. Because of greater

(Continued on Page 376)

Table 2. Anergic Patients After Retesting 7 to 10 Weeks After Institution of Antituberculous Chemotherapy

Case	Age	Race	Extent	Retest (7-10 Weeks) Commercial PPD	Retest (7-10 Weeks) Stabilized PPD
1	49	C	FAC	7 mm	6 mm
2	53	N	FAC	>10 mm	>10 mm
3	48	C	FAC	>10 mm	>10 mm
4	54	C	FAC	8 mm	5 mm
5	76	C	FAC	>10 mm	>10 mm
6	82	C	FAC	>10 mm	>10 mm

Abbreviations: C = Caucasian; N = Negro; FAC = far advanced cavitary disease.

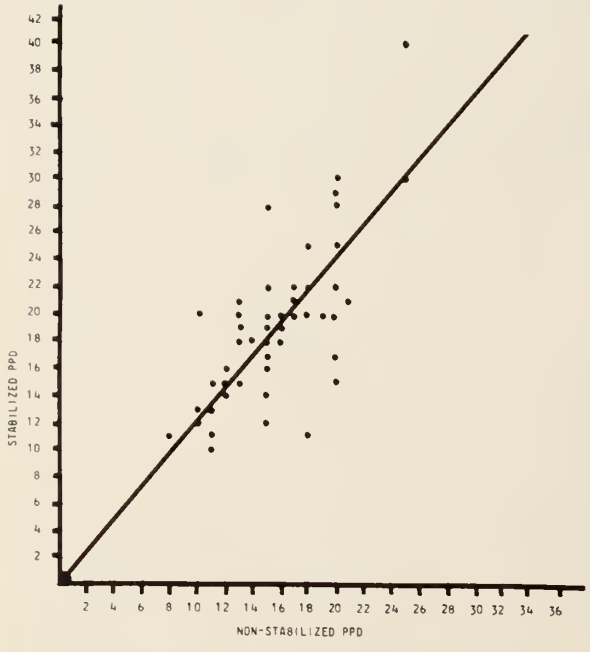
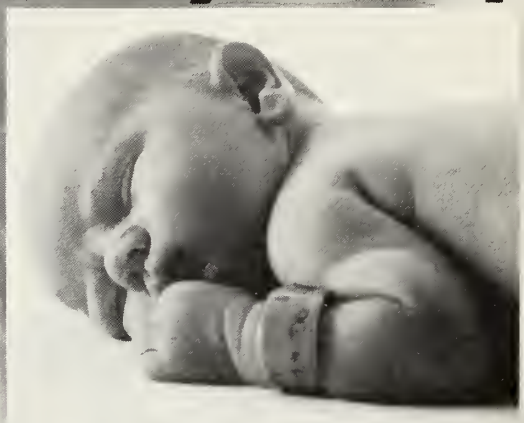


Fig. 2. Size of induration when compared, commercial PPD vs stabilized PPD, was statistically insignificant with a correlation factor of r = +.84.



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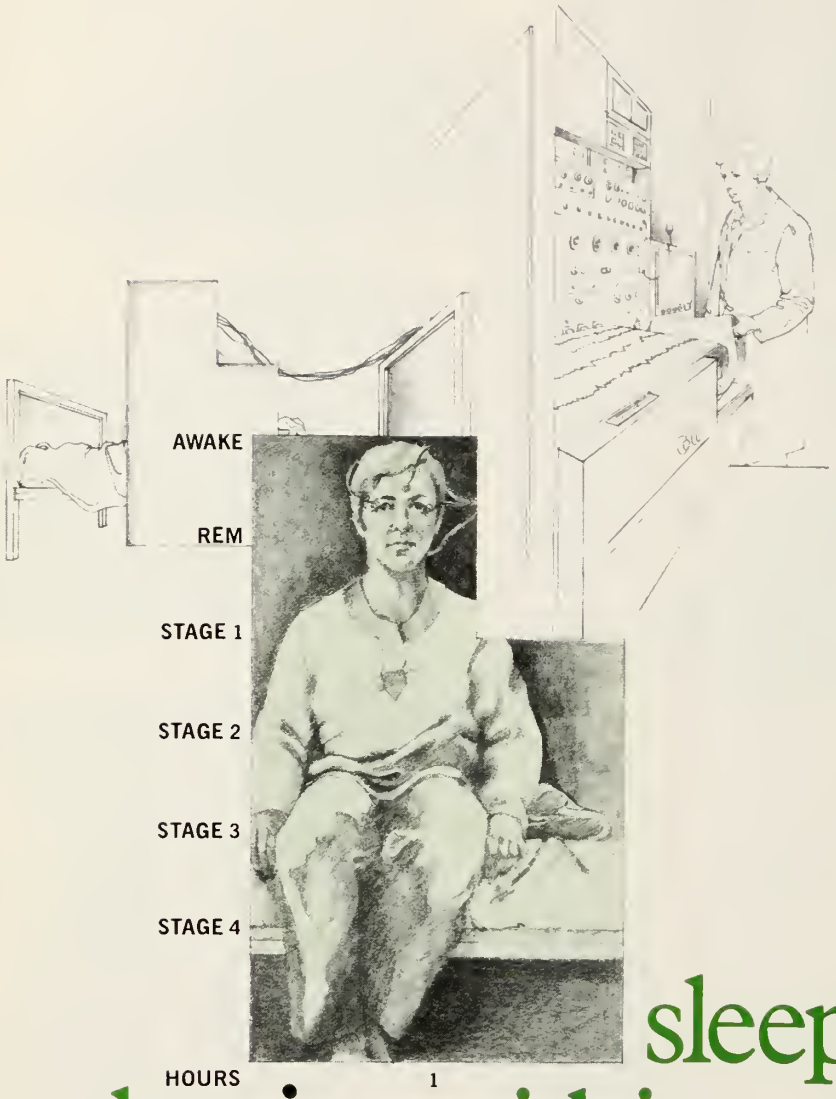
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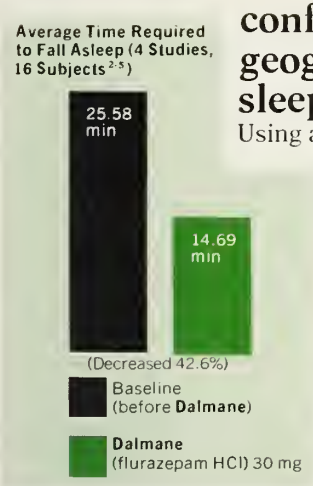
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confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

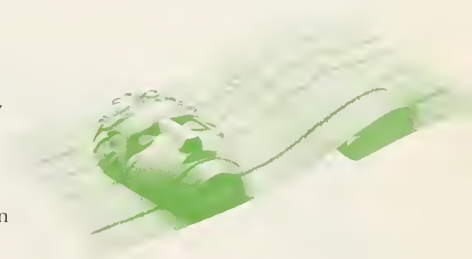
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

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Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare



A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it, for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the necessity

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company



A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year.

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It

for a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful. On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

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should in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

economy and less stringency in preparation, the liquid stabilized antigen is the best preparation for tuberculin skin testing. Almost all patients will react if retested after antituberculosis chemotherapy. Therefore, repeatedly negative skin tests effectively rule out active *M. tuberculosis infection*, provided that diseases or drugs known to cause anergy are not present.

The advances in immunology during the last decade suggest that perhaps in the near future a simple blood test will be available and that the skin test as performed today will not be necessary.

Summary

A commercial, intermediate-strength, purified, protein derivative was compared with a stabilized, intermediate-strength, purified, protein derivative in 100 patients with documented active tuberculosis due to *M. tuberculosis*.

No significant differences were found in regard to skin sensitivity responses. Ninety-three of the patients tested were definitely positive (greater than 10 mm induration) to both antigens. One patient was positive for stabilized PPD but showed a doubtful reaction (5 to 9 mm induration) to commercial PPD. The remaining six patients did not react to either agent at all and were considered anergic.

The uniformity of sensitivity to both preparations was probably due to the prompt administration of commericial PPD after reconstitution, preventing significant adsorption to the wall of the containers.

All six anergic patients were retested seven to ten weeks after administration of antituberculous chemotherapy, resulting in four having positive tests and two with doubtful reactions.

Repeatedly negative skin tests effectively rule out active *M. tuberculosis* infection, provided that diseases or drugs known to cause anergy are not present.

Acknowledgment: I am grateful to James T. Taguchi, M.D. for editing this manuscript, to the late Lynne E. Baker, M.D. for permitting me to study patients from Stillwater Sanatorium, and to Mrs. Janice G. Pence, R.N., for her technical assistance.

Note: After the conclusion of this study, MSD commercial PPD was withdrawn from the market, and the concentration of the stabilized product was reduced.

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Maternal Deaths Associated With Appendicitis

By the OSMA Committee on Maternal Health*

FROM TIME TO TIME, this column carries reports of various cases which bear an unusual savor, pertaining to controversial clinical aspects of obstetric practice.

Problems involved in attaining an *accurate* diagnosis of acute appendicitis in the pregnant or puerperal patient are all *too* numerous, rendering the patient a highly vulnerable human being. Fortunately, appendicitis is not common in this patient, yet the student and the physician must always be on the alert to recognize the pathology.

Herewith the Committee presents two interesting cases, one a maternal death, the other a nonmaternal death, both containing controversial features.

Case No. 1669

This was a 27-year-old, white, Para II, who died six days postpartum. She had had one previous term pregnancy delivered without complication. With a last menstrual period of December 1971, the patient registered in her third month, making regular monthly visits. Late in the third month, she developed right inguinal and iliac crest pain radiating into the back; this was diagnosed as a urinary tract infection and treated with "sulfa" and Macrodantin. The pain persisted. An orthopedic consultation was obtained; on x-ray study, a mass in the right psoas muscle was discovered, while the result of intravenous pyelogram was negative. Fever developed, and the patient was admitted on the orthopedic service at 3:05 PM on June 15 (about six months pregnant); treatment with Keflin was followed by a subsiding fever. A medical consultant suggested a bone marrow biopsy to rule out sarcoma or bone metastasis. A sternal puncture was performed on June 21, immediately followed by respiratory and cardiac arrest. The usual prompt treatment restored breathing and cardiac action, but the patient remained in coma. Intermittent, paroxysmal auricular tachycardia and auricular fibrillation followed. On June 28 (approximately 28 weeks gestation), labor began intermittently, continuing until the patient delivered spontaneously (without medication or anesthesia), over a median episiotomy; the baby weighed 1260 gm (2 lb 3 oz) and survived for 15 minutes. Transferred to the intensive care unit, the patient was supported, but gradually declined, and was pronounced dead on July 8.

Cause of Death (Autopsy): Large psoas abscess, possibly secondary to previous acute appendicitis, with a small sinus tract entering the terminal ileum; bilateral pneumonia with upper lobe abscesses; cerebral edema; septicemia; old pyelonephritis scars, left kidney.

Comment

Rather amazed at the bizarre development of the patient's clinical course, the Committee studied the case with maximum interest. Members agreed the pregnancy "masked" signs of the true pathology present, and conjectured that through misadventure, the mediastinal structures had been entered. By a *narrow* vote, members voted this a *preventable* maternal death.

Case No. 1664

A 25-year-old, white, Para O, cesarean I, died 106 days postpartum (postoperative). She was usually well but had suffered "joint pains" the past year, and last menstrual period was on May 10. The patient registered in the second month of pregnancy and made 15 visits. Her physical findings were normal; blood type was A-negative, and the expected date of delivery was February 16. She was admitted on March 5, apparently "overdue," abdomen large, and x-ray pelvimetry indicated a mildly contracted pelvis, with "a good-sized baby." An obstetrics and gynecology consultant concurred in recommendation of a primary cesarean section. On March 6, a low cervical section was performed under spinal anesthesia. Found: hydramnios, 3000 cc and delivery of a living 2940-gm (5 lb 3 oz) baby, Apgar score 4, copious mucous. The pediatrician was summoned (anomalous baby), and diagnosed the newborn as having a tracheobronchial fistula. The infant underwent surgery and did well. The patient followed a rather febrile course, the lochia cultured *Escherichia coli.* She responded to antibiotic therapy and was discharged April 15.

On or about April 7 (four weeks postpartum), the patient developed painful, swollen joints without redness. She was readmitted May 24, and an internist was consulted. Laboratory studies: erythrocytes 4,200,000 per cu mm; leukocytes 2,000 per cu mm; with 43 percent segmented neutrophils, 37 percent lymphocytes, and 2 percent monocytes. The first LE preparation test was negative, but the second proved to be positive to diagnose lupus erythematosis. X-ray films revealed rheumatoid arthritis. Therapy with antibiotics was followed by a normal temperature from May 29 to June 6, when the patient developed low abdominal pain, vomiting, and

*A continuous statewide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

diarrhea, and on June 10, she had a temperature of 40.0 C (104 F). X-ray studies reported "diffuse lower bowel gas, no masses or free air." After surgical consultation on June 13, it was decided to continue antibiotics and wait; but with no improvement and a continued fever, the decision was changed on June 16. An exploratory laparotomy was performed. Found: gangrenous appendix, pelvic abscess, adhesions between the bowel and uterus. An appendectomy was performed, the abscess was drained: *E coli* was cultured from the peritoneum. On June 17, abdominal distention began; a Levin tube proved to be effective. Oliguria developed followed by dyspnea and "coffee-ground material" was expelled through the Levin tube. In spite of therapy, the patient pursued a down-hill clinical course and died on June 21. There was an autopsy.

Cause of Death (Autopsy): Lupus erythematosis; generalized peritonitis; septicemia *(E. coli);* status 3½ months postcesarean operation, etc.

Comment

The prolonged chain of clinical events in this case provoked a lengthy discussion by the Committee. Of course, the matter of incidental appendectomy during elective cesarean section came to the front of "table talk"; less than a fifth of the members have performed "routine appendectomies" at the time of the elective cesarean operation, and none would do it with the "emergency section." Of course, all of this was in retrospect. After prolonged deliberation, the Committee voted this a nonmaternal death, unavoidable catastrophy.

Comment of Consultant

The following comment of a consultant specializing in obstetrics and gynecology was given at the request of the Committee:

Less than 100 years ago, the American pathologist, Reginald Fitz, in 1886, is credited with first solving the riddle of appendicitis, and the famed New York obstetrician and gynecologist, P. Mundo, in 1894, presented the first report of acute appendicitis complicating pregnancy.

Notwithstanding the "physiological leukocytosis of pregnancy," the presence of leukocytosis in excess of a 10,000 count, a progressive increase in blood sedimentation rate, plus temperature elevation, indicates infection! Infection of any type associated with pregnancy or the puerperium is serious. Infection, plus vomiting, diarrhea, abdominal pain must be considered appendicitis until proven otherwise. The pregnant woman with acute appendicitis is first a surgical problem and second an obstetrical problem. The postpartum patient with appendicitis, likewise, is primarily a surgical patient.

The first case is preventable, in my opinion, due to the error in diagnosis, first reference the urological diagnosis, and second, reference to the orthopedic surgeons' and internists', diagnosis of sarcoma. The autopsy report (as given) does not support the hypothesis of "misadventure" at time of sternal bone marrow biopsy.

The second case presents "text book symptoms" of appendicitis, ie, abdominal pain, vomiting, diarrhea, and temperature of 40.0 C (104 F). A delay of ten days for observation with no improvement was then followed by laparotomy. Certainly the ten-day delay (in fact any delay) must be considered "preventable" even though the Committee correctly voted the case a *nonmaternal* death.

Appendicitis associated with pregnancy, labor, or the puerperium, according to most authorities, has a 50 percent mortality rate when associated with rupture and peritonitis. Surgery is advocated not to treat appendicitis, but to prevent peritonitis. There is no place for complacency or delay in this disease entity.

With the advent of "peer review" and PSRO, the physician reviewers must give consideration to the fact some appendices will be reported as "no pathological condition," but those patients will not die of a ruptured appendix and peritonitis. The trade-off is well worth it to the patient who is saved.

As to the prophylactic appendectomy at time of the cesarean section operation, the skill and competency of the operator to perform abdominal and intestinal surgery is a primary factor. The cecum and appendix in the patient involved in pregnancy, labor, or the puerperium will normally be displaced cephalicward and laterally. No general rule can be propounded. Certainly blood loss, anesthetic time, condition of the viscera should be surgically evaluated, as should consent of the patient. Gastric and intestinal decompression with a Levin or Waganstein tube is highly recommended following any surgical attack on the intestine during a cesarean section.

Generic and Trade Names of Drugs

Nitrofurantoin macrocrystals—Macrodantin (Eaton)
Sodium cephalothin—Keflin (Lilly)

Professional Activities



AMA Grants to Medical Schools Reach New Peak at $1,265,000; Figures Broken Down for Ohio

THE NATION'S medical schools are receiving $1,265,000 in unrestricted grants from the American Medical Association Education and Research Foundation (AMA-ERF), according to Foundation President Kenneth C. Sawyer, M.D., of Denver.

Ohio's share in the AMA-ERF program was proportionate. At the recent OSMA Annual Meeting in Cleveland, checks were presented to the dean, or his representative, of each of the following schools in the amounts shown:

Case Western Reserve University School of Medicine	$10,350.74
Ohio State University College of Medicine	15,250.59
University of Cincinnati College of Medicine	18,393.75
Medical College of Ohio at Toledo	5,110.76

There were 157 loans made to Ohio medical students in 1973, totaling $202,500. Since the program was initiated in 1962 through 1973, there have been 2,025 loans made to Ohio medical students for a total of $2,259,850.

This national sum, representing contributions received during the calendar year 1973, is the largest amount distributed in ten years and the fifth largest since the AMA began its aid to education program 23 years ago.

"Since 1951, the AMA-ERF has distributed $25,108,234 to the medical schools," Dr. Sawyer said. "Medical school deans may use these funds in any way they see fit—to increase their staffs, apply towards scholarships and loans, new laboratories or other expansion programs, or supplement teacher salaries."

One hundred per cent of every dollar contributed to the Foundation goes for the purpose designated, Dr. Sawyer explained. All fund-raising costs are borne by the American Medical Association.

"Physicians and their wives, through the Woman's Auxiliary to the AMA, are the heaviest contributors to AMA-ERF," Dr. Sawyer said. "In 1973, the Foundation received $1,921,113 for its various programs. Physicians and the Auxiliary contributed $1,444,196 of this amount.

"Other contributors were foundations, $265,232; laymen, $87,319; state, county and other medical societies, $73,318; and pharmaceutical industry, $51,048."

Dr. Sawyer also reported on the AMA-ERF's loan guarantee program for medical students, interns and residents. Since its inception in 1962, the Foundation has guaranteed 51,797 loans totaling $59,481,298 through the end of 1973.

"While other loan programs and grants are available to these individuals, many find that the sums are inadequate to cover all of their training expenses," Dr. Sawyer said. "Because the AMA-ERF puts up collateral in their behalf, they are able to obtain supplemental funds which they could not borrow in any other way."

The AMA-ERF also spends more than $500,000 annually in support of community and rural health projects and other health-related activities.

Officers and AMA Delegates Elected at the 1973 Annual Meeting

Dr. James L. Henry, of Grove City, was installed as President of the Ohio State Medical Association at the final session of the House of Delegates on May 15 during the 1974 OSMA Annual Meeting in Cleveland. He was named President-Elect at the 1973 Annual Meeting in Columbus after serving six years on The Council as Treasurer and Secretary-Treasurer.

Dr. Maurice F. Lieber, Canton, was named President-Elect and will succeed to the Presidency at the 1975 Annual Meeting in Columbus. Dr. Lieber has served on The Council as Councilor of the Sixth District since 1969.

Dr. Charles Edward Pichette, Youngstown, was elected Councilor of the Sixth District for the remaining year of the unexpired term of Dr. Lieber. A graduate of State University of New York at Syracuse in 1938, he is a Fellow of the American College of Surgeons and specializes in urology.

Dr. Stephen P. Hogg, Cincinnati, was reelected Councilor of the First District.

Dr. John C. Smithson, Findlay, was reelected Councilor of the Third District.

Dr. John J. Gaughan, Cleveland, was elected Councilor of the Fifth District. He had previously been appointed by The Council to fill part of the unexpired term of the late Dr. David Fishman.

Dr. Robert E. Rinderknecht, Dover, was reelected Councilor of the Seventh District.

Dr. Thomas W. Morgan, Gallipolis, was reelected Councilor of the Ninth District.

Dr. Robert G. Thomas, Elyria, was reelected Councilor of the Eleventh District.

Councilors in the midst of two-year terms are: Dr. James G. Tye, Dayton, Second District; Dr. George N. Bates, Toledo, Fourth District; Dr. Richard E. Hartle, Lancaster, Eighth District; and Dr. James C. McLarnan, Mt. Vernon, Tenth District.

Dr. William M. Wells, Newark, is serving his first three-year term as Secretary-Treasurer.

Dr. Oscar W. Clarke, Gallipolis, as Immediate Past President, will serve an additional year on The Council.

Dr. William R. Schultz, Wooster, has retired from The Council after serving since 1965 as Councilor of the Eleventh District, President-Elect, President, and Past President.

The following physicians were reelected Delegates to the American Medical Association for additional two-year terms beginning January 1, 1975: Dr. Richard L. Meiling, Columbus; Dr. Lawrence C. Meredith, Oberlin; Dr. Robert N. Smith, Toledo; and Dr. Robert N. Tschantz, Canton.

Dr. John E. Albers, Cincinnati, was elected an Alternate Delegate to AMA to fill the remaining part the unexpired term of the late Dr. David Fishman. He also was elected for a two-year term as Alternate Delegate beginning January 1, 1975.

Alternate Delegates reelected for two-year terms beginning January 1, 1975 are: Dr. Dwight L. Becker, Lima; Dr. B. Leslie Huffman, Jr., Toledo; Dr. H. William Porterfield, Columbus.

AMA Delegates in the midst of terms are: Dr. Oscar W. Clarke, Gallipolis; Dr. Henry A. Crawford, Cleveland; Dr. Harry K. Hines, Cincinnati; Dr. W. J. Lewis, Dayton; and Dr. P. John Robechek, Cleveland.

Alternate Delegates in the midst of two-year terms are: Dr. George N. Bates, Toledo; Dr. Richard L. Fulton, Columbus; Dr. Jerry L. Hammon, West Milton; Dr. Jack Schreiber, Canfield; and Dr. William R. Schultz, Wooster.

Because of the time element involved, only this brief summary of election results could be included in this issue of *The Journal*. Watch for the July number and complete reports of the 1974 Annual Meeting, including official minutes of the House of Delegates.

Proceedings of The Council

Meeting of April 6, 1974

THE COUNCIL of the Ohio State Medical Association met at the Terrace-Hilton Hotel, Cincinnati Ohio, April 6, 1974. All members were present, except George N. Bates, M.D., Toledo. Hart F. Page, Executive Director was also present.

The President announced that Senator Kennedy and Congressman Mills have introduced National Health Insurance legislation, agreed upon by both, in the Congress. Councilors were requested to write to their Congressmen for copies of the bills.

Mr. Rader Promoted

By official action, the Council voted to advance Mr. David Rader to the position, Director, Department of State Legislation and Associate Executive Director.

Committee on Judicial and Professional Relations

The President presented the minutes of the Judicial and Professional Relations Committee meeting of March 13, 1974.

The Council approved the minutes and voted to transmit the reports covered therein (Resolution 3-73 and Resolution 30-73) to the 1974 House of Delegates of the Ohio State Medical Association.

Certificate of Need

The President announced a hearing to be conducted April 29, 1974, by John W. Cashman, M.D., Ohio Director of Health, with regard to revision of the Ohio State Plan for Hospital and Medical Facilities Construction and Modernization. "The Plan, when finalized after the hearing, will serve as the basis for administration of the federal Hill-Burton hospital construction and modernization program and the administration of Section 1122 of federal Public Law 92-603, 'Limitation on Federal Participation for Capital Expenditures.' "

It was the opinion of the Council that:

1. Offices of physicians in private practice must not be classified as facilities under this program.

2. Regional "determination of need" must not be destroyed by the action proposed by the Ohio Director of Health.

The following plan of action was adopted by the Council:

1. County medical societies be alerted to the hearing on April 29, and its implications.

2. The Ohio Academy of Family Physicians, Ohio Society of Internal Medicine, the Ohio Osteopathic Association of Physicians and Surgeons, and other appropriate organizations be notified of the hearing, and alerted to the implications with regard to the private practice of medicine.

3. Mr. James E. Pohlman, OSMA Legal Counsel, be instructed to testify for the Association on April 29, with as many members of Council as possible to be in attendance.

4. The Ohio Health Resources Council be called into emergency session.

5. That the appropriate subcommittee of the OSMA Committee on Government Medical Care Programs assist with preparation of testimony.

6. That appropriately timed news releases be issued with regard to the Association's opinion on the plan and its dangers to the health of the public.

Committee on Government Medical Care Programs

The minutes of the March 13, 1974 meeting of the Committee on Government Medical Care Programs were presented by the President.

The section of the minutes devoted to Professional Standards Review Organizations and to Peer Review Systems was referred back to the Committee, along with the statement of Dr. Oscar W. Clarke to the AMA House of Delegates on December 3, 1973, ratified by the Council March 9 and 10, 1974, and with information developed at the April 6, 1974 meeting of Council, asking the Committee to reconsider its report on the basis of those facts and information.

The Executive Director was instructed to contact Moshman and Associates for results of its survey before approval of a proposed survey of unpaid claims for Medicaid.

The remainder of the report was accepted for information.

(Continued on Next Page)

(PROCEEDING—*Contd.*)

Committee on Health Manpower

The minutes of the March 13, 1974 meeting of the Committee on Health Manpower were presented by the President and were accepted for information.

With regard to "physicians' assistants," the Council voted to advise the Committee that it "looks favorably on the concept of registering" and that it is favorable to the idea of certification of a physician assistant provided that the P.A. shall be under the responsibility of a specific physician and provided further that such certificate be valid only when the P.A. is serving with that physician.

The Council asked for additional information on the program of the National Board of Medical Examiners.

The Chairman, members of the Committee and its secretary, were commended on the excellence of the meeting conducted by the Committee.

Harrison County Matter

A problem arising in Harrison County was referred to the Joint Officers Conference of the OSMA, Ohio Association of Osteopathic Physicians and Surgeons and the Ohio Hospital Association, for consideration and action.

Request from Medical Assistants

A request for funds in behalf of the American Association of Medical Assistants—Ohio State Society, under date of April 4, 1974, was deferred, since it was not officially presented by the officers of the Association through the Ohio State Medical Association Advisory Committee.

OSMA Building Program

The Council voted to **approve** a "Ribbon Cutting Ceremony" for the new OSMA office building May 1, 1974.

The Council **approved** expenditures of:

1. $1,854.99 for furnishing the reception area.
2. $7,067.53 for over draperies as well as under draperies for sunlight control.
3. $8,871.64 for change orders.

The original contract was $466,050.00. The total cost to date is $474,921.64.

Endorsement

The Council endorsed Dr. Antonio Rodriguez-Antunez for AMA recommendation to an appointment to the FDA Medical Radiation Advisory Committee.

Dr. Schultz Commended

The Council voted to commend William R. Schultz, M.D., for his long service as a member of The Council, as President-Elect, President and Past President, and thanked him for the wisdom and devotion he brought to the Ohio State Medical Association and The Council.

September Meeting

The Council expressed preference for a September 21-22 fall meeting at White Sulphur Springs with a September 14-15 meeting as the alternative.

Attest: Hart F. Page
Executive Director



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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during March and April 1974. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

ALLEN
R. K. Pudupakkam
Lima

ASHTABULA
Hector T. Abueg
Conneaut

BELMONT
Satinder S. Bhullar
Bellaire
Chaganlal N. Patel
Bellaire
Chong Sook Lee Sohn
Martins Ferry

BUTLER
Bobby C. Campbell
West Chester
Gilbert J. Gordon
Middletown

CLARK
James M. Pomputius
Springfield
William F. Smith
Dayton

CLINTON
Edwin P. Hiatt
Wilmington

COLUMBIANA
Andres B. Lao, Jr.
East Liverpool

COSHOCTON
Jin Dae Kim
Coshocton
Sang Moo Suh
Coshocton

CUYAHOGA (Cleveland)
John A. Bergfield
Jeffrey Che Hsi Chen
Avram M. Cooperman
Michael D. Hall
Maurice R. Hanson
Hector Lardani
Richard J. Lederman
Harold Mars
Drogo K. Montague

CUYAHOGA (contd.)
Wilfredo M. Paras
Daniel F. Phillips
Arnold D. Rothner
Raymond J. Scheetz, Jr.
Peter H. Slugg
Marjorie M. Smith
Patrick J. Sweeney
Mahendra I. Vyas
Asa J. Wilbourn
Giorgio G. Zanettin
Margaret G. Zelch

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Bellefontaine

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Estelito A. Moraleja

PORTAGE
Peter Fu Ming Chen
Windham

RICHLAND
Lawrence L. Gibson
Mansfield

ROSS
Theodore J. Albertowicz
Chillicothe
Cheng Chung Yen
Chillicothe

SENECA (Tiffin, except as noted)
Adonis C. Amparo
Seri Kaosal
Virgilia A. Lim
Hashem Moosavi-Far
Fostoria

STARK
Richard A. Scott, Jr.
Canton

SUMMIT (Akron except as noted)
Philip Allen Anderson
Alex Azar
Cuyahoga Falls
Hobart Don Blair
Donald Braden
Robert A. Burnstine
David Glenn Burket
John Dale Chulik
Robert V. Davidson
Ernest R. Estep
Frank Charles Forshew
Michael A. Francis

SUMMIT (contd.)
Paul D. Gatewood
Terry L. Hackney
John R. Hansel
Lester E. Krenning
Yoon Suk Lee
Barberton
Robert E. Ley, III
Joseph N. G. Lua
Barberton
Paul W. McFadden
Frederick K. Mueller
Rafael P. Osoteo, Jr.
Monroe Falls
Anthony J. Parnofiello
John W. Peterson
Marvin Stanley Platt
George T. Ralph
Renato E. Reodica
Michael David Serene
Maxwell B. Snedegar
Robert L. Sobieski
Michael L. Turner
Ralph C. Whalen

TRUMBULL (Warren)
Nazir Ahmed
Luis Enrique Cali
Ashok G. Kumar
Nigel Kevin Newman

WASHINGTON
Fortunato R. Macatol
Marietta
Edward M. Scileppi
Marietta

WAYNE (Wooster)
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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

Obituaries

Sylvester Louis Agnone, M.D., Canton and Louisville; Ohio State University College of Medicine 1922; aged 79; died April 17; former member of OSMA and AMA.

Vernon Wolfert Astler, M.D., Boynton Beach, Fla.; formerly of Cincinnati; Eclectic Medical College, Cincinnati, 1921; aged 80; died March 24; member of OSMA and AMA.

Clarence Andrew Berger, M.D., Toledo; Toledo Medical College, 1903; aged 95; died April 10; member of OSMA and AMA.

George Webster Binkley, M.D., Tryon, N.C.; formerly of Cleveland; Western Reserve University School of Medicine, 1930; aged 69; died April 3; member of OSMA and AMA.

George Lewis Clauer, M.D., Houma, La.; formerly of Springfield; Ohio State University College of Medicine, 1947; aged 51; died April 8; former member of OSMA.

Victor William Fischbach, M.D., Cincinnati; University of Cincinnati College of Medicine, 1918; aged 79; died April 8; member of OSMA and AMA.

Conrad Murray Fisher, M.D., New Philadelphia and Dover; Western Reserve University School of Medicine, 1943; aged 62; died March 27; member of OSMA and AMA.

Stanley Milton Goldhamer, M.D., Cleveland; University of Michigan Medical School, 1929; aged 69; died April 17; member of OSMA and AMA.

Kenworthy Mansfield Hoge, Jr., M.D., Canton; University of Pennsylvania School of Medicine, 1938; aged 61; died April 14; member of OSMA and AMA.

Irwin Kaplan, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1938; aged 63; died March 28; member of OSMA and AMA.

Albert L. Lewin, M.D., Cleveland; medical degree from the university at Bonn, Germany in 1927; aged 71; died April 18; member of OSMA and former member of AMA.

Ernest Fred Maag, M.D., Middleport,; Ohio State University College of Medicine, 1920; aged 81; died April 12; former member of OSMA and AMA.

Helen Margaret Magly Elkins, M.D., Lakeside; Medical College of Virginia, 1926; aged 74; died April 9.

Paul Anthony Mielcarek, M.D., Cleveland; Western Reserve University School of Medicine, 1932; aged 66; died April 29; member of OSMA and AMA.

Ray Thomas Odell, M.D., Hiram; University of Wooster, Medical Department, Cleveland, 1911; aged 87; died April 16; member of OSMA and AMA.

Walter S. Pavluk, M.D., Parma; George Washington University School of Medicine, 1947; aged 52; died April 9; member of OSMA and AMA.

Harry Gordon Sloan, M.D., Cleveland; Johns Hopkins University School of Medicine, 1906; aged 92; died April 17; member of OSMA and AMA.

Clarence Stafanski, M.D., Youngstown; Eclectic Medical College, Cincinnati, 1917; aged 82; died April 1; member of OSMA and AMA.

Clarence M. Weidenthal, M.D., Cleveland; Western Reserve University School of Medicine, 1921; aged 77; died April 6; member of OSMA and AMA.

Karl Frederick Welte, M.D., Cleveland; medical degree from university at Munchen, Bayern, Germany, 1934; aged 68; died March 28; member of OSMA and AMA.

Justin Biechele Whelan, M.D., Cleveland; Western Reserve University School of Medicine, 1919; aged 80; died April 7; former member of OSMA.

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Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

IT WAS James Russell Lowell who said "talent is that which is in a man's power." I don't think anyone will question that it takes a very special talent to be a good physician. And when that special talent spills over into another, completely different area, it deserves very special recognition indeed! What else am I referring to than the outstanding and beautiful Art Show that was planned for the OSMA Annual Meeting at the Sheraton-Cleveland Hotel and in which doctors' wives also played an important role? Some 150 artists exhibited close to 400 pieces of art.

Exhibitors were limited to two art pieces per category and those categories included paintings —water color; paintings—oil paintings and acrylics; sculpture; photo arts; crafts and construction; graphics. I wish I had the space to do justice to that Show and the efforts of its talented chairman, Dr. Victor C. Laughlin.

Members of the **Cuyahoga County** auxiliary served as hostesses (a number of auxilians were among the exhibitors from over the state). The Cuyahoga women also assisted with the receiving and dismantling of the display with the assistance and advice of the Art Councilors and the Judges. Serving on that special committee were: Mrs. William Mourad, chairman; Mrs. Kenneth Harshman, Cuyahoga president; Mrs. M. E. Bobey, Mrs. N. Economo; Mrs. Joseph Fegan, Mrs. Julius Gerlach, Mrs. W. H. Mast, Mrs. Victor Laughlin, Mrs Abdul Naji, Mrs. Robert Rosner, Mrs. A. Tramer, Mrs. Myron Volk and Mrs. Robert Weekley.

Child Abuse

It proved to be a most enlightening and rewarding venture—that very recent Conference on the Abused and Neglected Child that was sponsored by our state auxiliary and the Ohio Department of Public Welfare. Much credit is due our indefatigable Mrs. Albert May, chairman of Community Health Services. Held at the Downtown Holiday Inn in Columbus, the conference introduced and developed the jointly sponsored project to focus on involving the total community with special emphasis on the medical profession to achieve continued cooperation and increased reporting when child abuse and neglect is suspected. During the meaningful workshop sessions, strategies for specific projects were developed.

Those taking part in the program included: David Schwertfager, chief, Bureau of Services to Families and Children; Mrs. May; Oscar Clarke, M.D., OSMA President; Jean Schafer, program development specialist, Children's Protective Services; Rosalyn Bandman, director of social services, Children's Hospital, Columbus; Hans Stroo, M.D., child psychiatrist, Children's Mental Health Clinic; Philip Ambuel, M.D., Anita Brewer, supervisor child abuse unit, Franklin County Children Services Board; Mary Evans, supervisor, dependency department, Court of Domestic Relations, Franklin county; Paul Coleman, assistant director, Ohio Department of Public Welfare.

Here and There

Nursing scholarship students were honored recently at a smorgasbord luncheon of the **Franklin County** auxiliary . . . ten students are currently enrolled in the nursing program at Grant, Mt. Carmel, University and Riverside Hospitals . . . $4,000 were distributed by the Franklin group last year to provide tuition and other fees; **Lucas County's** annual Invitational Dessert Tea was a March event at which Barbara Greene Kilberg discussed "The Contemporary Woman in To-day's Society"—Mrs. Kilberg is vice-president for Academic Affairs at Mt. Vernon College in Washington, D.C.; a St. Patrick's Day Tea featured the March meeting of the **Scioto County** auxiliary at which Sheriff John Knauff discussed crime and self-defense and gave helpful hints on safeguards for the home . . . the April meeting was a luncheon and tour at Scioto County's Technical College and Vocational School . . . .

Butler County's "Old-Fashioned Talent Night" in which the doctors generously participated netted $2,312.00 at the auction held for the group's scholarship fund; a recent luncheon of the **Stark County** auxiliary was held at the Alliance Women's Club at which Dr. R. G. Hamrick, Superintendent of Alliance Public Schools was the honored guest . . . later there was a tour of the high school and "Glamoregan Castle," the administration building; Mrs. Emeliano Feliciano, third district director, presented a copy of "The Case for American Medicine" to the **Van Wert** auxiliary at a dinner meeting at Holiday Inn—

Mrs. Norman Marxen, president, discussed the distribution of funds for the nursery at the Van Wert County Hospital and the progress of the Mobile Meals program . . .

Tuscarawas County auxiliary honored its doctors at a Doctors' Day dinner held recently at Atwood Lodge at which Dr. Oscar Clarke, OSMA president, and Mrs. Clarke were present . . . . . Dr. Clarke commended the local newspaper editor, Harry Yockey, for his excellent editorials on health legislation which appear in his paper regularly—Mr. and Mrs. Yockey were also honored guests at the dinner; "1974 is a crucial election year" warns Mrs. Malachi W. Sloan, OMPAC liaison to WA-OSMA, in an April OMPAC appeal to all county auxiliaries—"the name of the game is $$$ to support men and women, Democrats and Republicans, who will work in behalf of medicine, in the halls of Congress or in our state legislature" . . . what's that about a word to the wise???

Cincinnati General Participates in Surgery-Anesthesia Studies

General Hospital of Cincinnati is one of 17 hospitals participating in a national study to investigate factors which influence postoperative outcomes in surgery and anesthesia.

The study is sponsored by the National Academy of Sciences and National Research Council and is funded through the Health Resources Administration. Study center is Stanford University School of Medicine.

Fifteen types of surgery which include most of the basic surgical services will be studied over a one year period. Technicians will gather data in respective hospitals, but no patient's record will be included without his consent. Both positive and negative results of surgery and anesthesia will be studied.

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Ribbon-Cutting Ceremonies Held for OSMA Headquarters Building

MAY 1, 1974 WAS A RED LETTER DAY in the annals of the Ohio State Medical Association. On the morning of that day, the ribbon was cut, portending the early moving of the OSMA Headquarters office into the building at 600 South High Street, Columbus.

The new property is on the southern fringe of the Columbus downtown area and is easily accessible from the combined Interstate Highways 70 and 71. High Street is the main street of Columbus, running north and south. Opening of the OSMA building is one more step in development and beautification of German Village, a large area south of the Columbus downtown area that has undergone extensive restoration in the last decade or more.

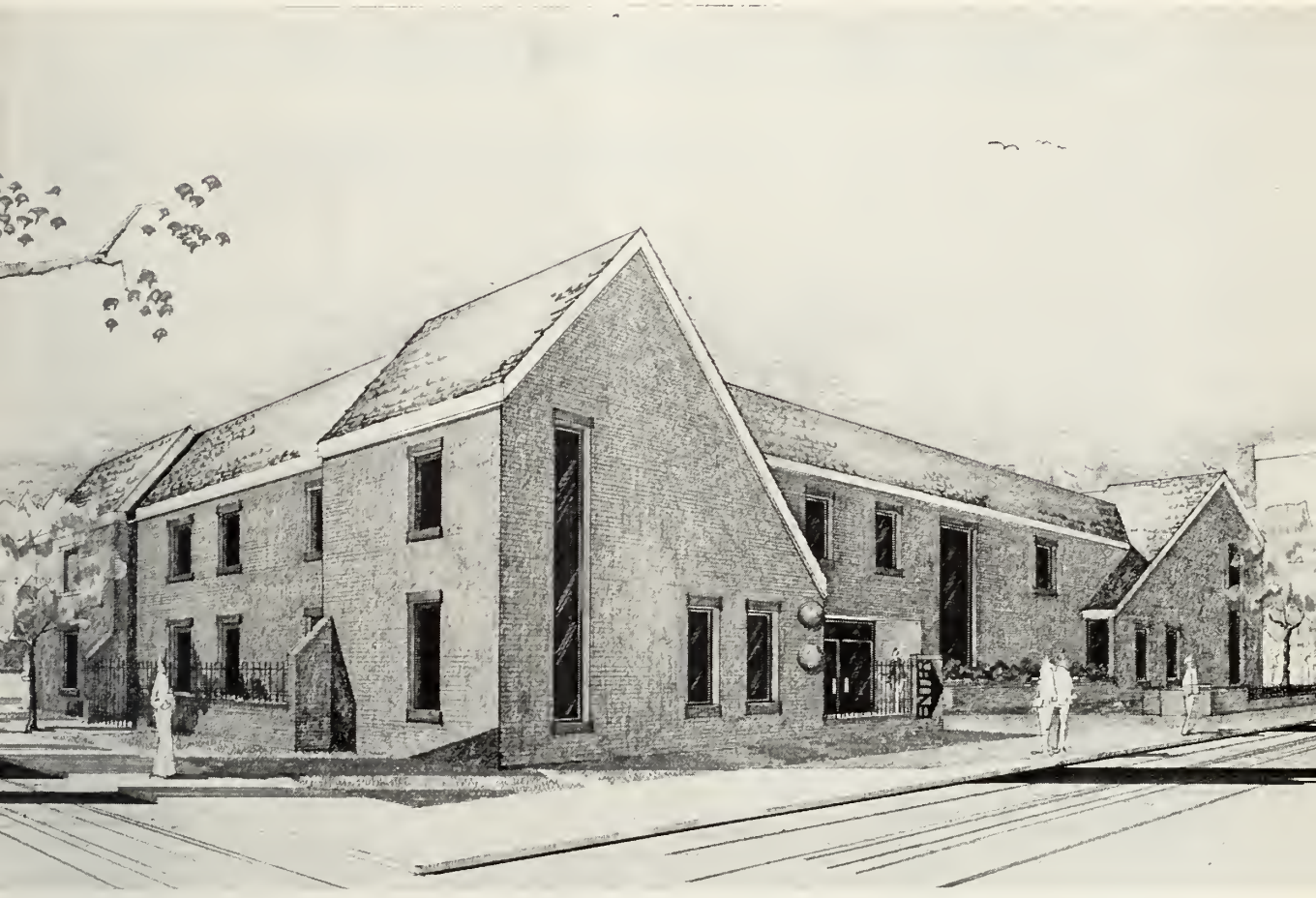
The entire exterior of the building, shown in the accompanying architect's sketch, is in keeping with the traditional architecture of the German Village without sacrificing the ultilitarian purposes for which it is intended.

The main entrance is 600 South High Street. A similar entrance will face east onto the parking lot that will accommodate some 40 cars. Arrange-



Shown cutting the ribbon to officially open the OSMA Headquarters building is Dr. William R. Schultz, who was President of the Association when plans for the building got under way. To his right is Dr. Oscar W. Clarke, 1973-1974 OSMA President; and to his left, Dr. James L. Henry, 1974-1975 President. Others shown in the picture, from left, are Mrs. Katherine Wisse, OSMA Comptroller and Secretary to the Building Committee; Dr. Maurice F. Lieber, named OSMA President-Elect at the recent Annual Meeting; Kevin Flaherty (third from right), architect; Hart F. Page, OSMA Executive Director; and Tom Radu, builder. Attending the ribbon-cutting ceremonies were members of The Council, and Past Presidents, and their ladies, as well as members of the Executive Staff and other key persons in the building program.

600 South High Street, Columbus



This is the architect's sketch of the new OSMA Headquarters building at 600 South High Street, Columbus. The exterior of the structure is in keeping with the traditional architecture of German Village, an area that has undergone considerable beautifications and restoration on the southern fringe of the Columbus downtown area.

ments have been made for additional parking space near the building to accommodate persons attending evening meetings. More than 17,000 square feet of floor space are provided on two floors above ground and a full basement.

The Academy of Medicine of Columbus and Franklin County will share space in the new building with offices on the second floor. The Academy will share use of the board room on the second floor and, for larger meetings, the meeting room on the lower level. As the schedule permits, meeting facilities will be made available for other professional groups such as the specialty organizations.

The decision to acquire the Association's own building was prompted by inflationary rental costs, especially in the downtown area, and the growing parking problem.

Ground-breaking ceremonies were held during the 1973 OSMA Annual Meeting in Columbus, on May 9, 1973. Construction began immediately after that. At latest report, only last minute details remained to complete the building. The headquarters office is scheduled to move into the new structure during June.

Remember, the New Address for
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Continuing Education Opportunities for Physicians in Ohio

June

University of Cincinnati College of Medicine (CONMED); Contact CONMED, 114 Medical College Bldg., Eden and Bethesda Aves., Cincinnati 45219:

Renal Disease Symposium — At Shrine Burns Institute, June 6.

Diagnostic Roentgenology — 16th Annual Refresher Course sponsored by the Radiology Department under direction of Dr. Benjamin Felson, June 10-14.

Medical Economics Seminar Combined with a Rhine River Cruise — Sponsored by the Medi-Club of the Academy of Medicine of Cincinnati, June 4-12.

Clinical Seminars on Emergency Medicine — Sponsored by the Medical College of Ohio:
June 5 — at Hardin Memorial Hospital, Kenton; 4:00-9:00 p.m.; tentative topic, **Surgical Emergency.**
June 11 — at Fisher-Titus Hospital, Norwalk: 4:00-9:00 p.m., **Burns.**

Seminars on Fundamentals of Surgery — Sponsored by the Medical College of Ohio at Toledo; Saturdays, 10:00 a.m. to noon; Room G-1, MCO. **Trauma,** June 1, 8, 15. For the June 8 seminar, visiting professor will be LaSalle D. Leffall, M.D., Howard University, whose topic will be **Abdominal Trauma.**

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

July

Association of Physicians of the State of Ohio —Quarterly meeting and program, July 12, Massillon State Hospital; contact Virginia S. Edwards, M.D., Secretary-Treasurer, 347 Lexington Ave., Mansfield 44907.

August

Ohio Academy of Family Physicians Annual Scientific Assembly—Cleveland Plaza Hotel, August 8-11; contact Mrs. Florence Landis, Executive Director, Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214.

Third Teaching Skills Workshop, sponsored by the OAFP at the Imperial House North, Morse Road at I-71, Columbus, Sept. 27-28; contact Mrs. Florence Landis, Executive Director, Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214.

September

Pediatrics and the Practicing Physician — Symposium sponsored by the Medical College of Ohio at Toledo and the Toledo Pediatric Society, Sept. 20-22, at Sheraton Westgate, Toledo. For additional information, write: Howard S. Madigan, M.D., MCO, P. O. Box 6190, Toledo 43614.

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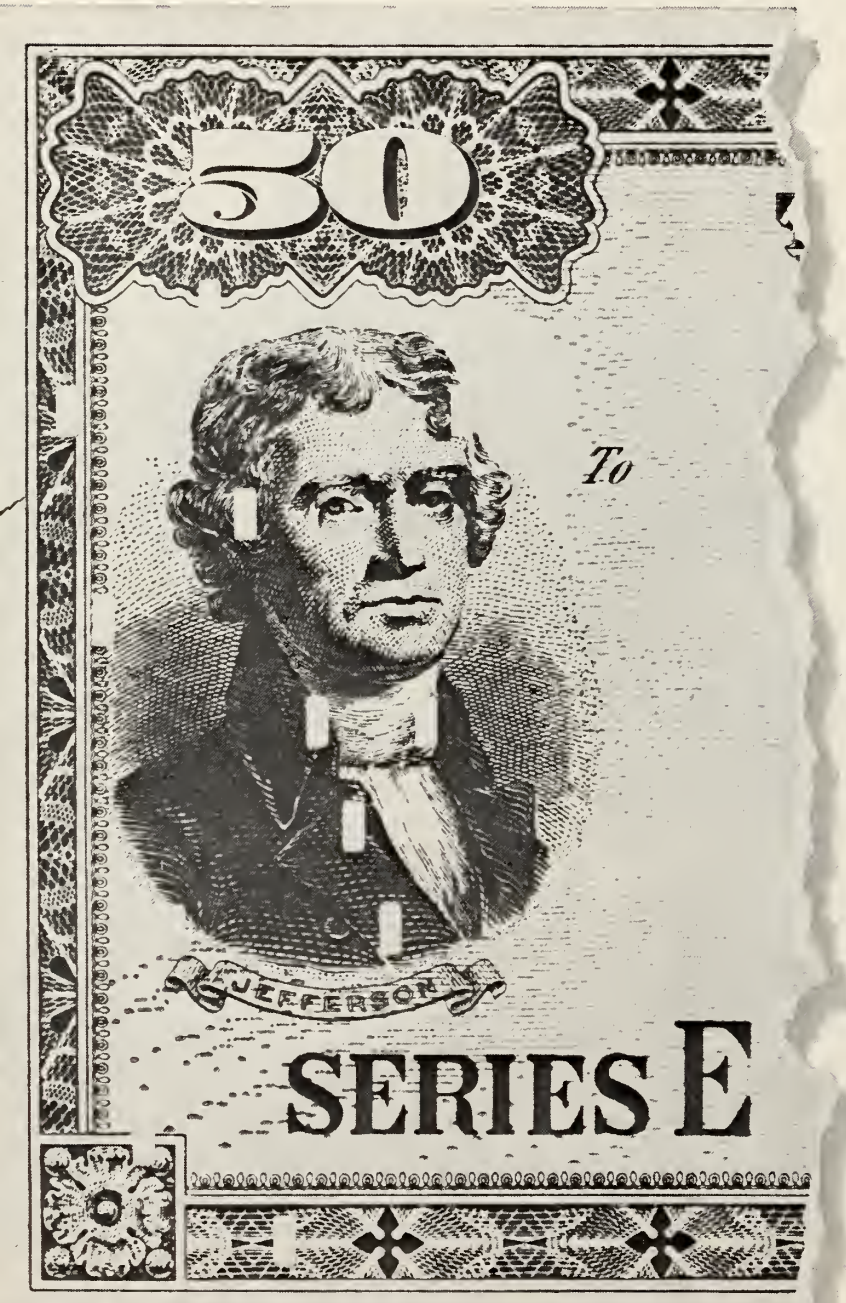


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Please turn to page 397 for a list of companies advertising in this issue of *The Journal.* (Other advertisers may be represented in other issues.) You may wish to keep this list handy and refer to it when detail men call on you. Thank those detail men whose companies are supporting your *Journal* and remind the others that they should be doing so.

A thin *Journal* means less information about your Ohio State Medical Association and its activities, and fewer clinical and scientific papers to help you keep up. —*The Publication Committee*

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LIPO-NICIN/100 mg. Each blue tablet contains: Nicotinic Acid .....100 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 5 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/250 mg.** Each yellow tablet contains: Nicotinic Acid .....250 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/300 mg.** Each timed-release capsule contains: Nicotinic Acid .....300 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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In This Issue:

Allergy Laboratories of Ohio 361

The Brown Pharmaceutical Co., Inc. 385, 393, 395

Burroughs Wellcome Co. 371

Daniels-Head & Associates, Inc. 387

Dorsey Laboratories, Div. of Sandoz-Wander, Inc. 353, 383

Harding Hospital 389

International Travel Advisors, Inc. (Holiday in the Orient) 349

Lilly, Eli and Company 364

McNeil Laboratories 359

Mead Johnson Laboratories 363

The Medical Protective Co. 387

Pharmaceutical Manufacturers Association 374-375

Roche Laboratories, Div. of Hoffman-LaRoche, Inc. .....Inside Front Cover, 347, 372-373, Inside Back Cover, Back Cover

Wm. H. Rorer, Inc. 355

Schmid Laboratories, Inc. 356-357

Turner & Shepard, Inc. 396

The Upjohn Company 350-351

University Center 384

Wendt-Bristol Co. 360

Windsor Hospital 382

Wolman Insurance Agency, Inc. 398

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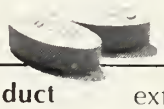
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Before prescribing, please consult complete product information, a summary of which follows:

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Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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Before prescribing, please consult complete product information, a summary of which appears on preceding page.

The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

VOLUME 70 JULY 1974 NUMBER 7

DISPLAY SHELVES

Original Articles

In Vitro Thrombosis in Acute Myocardial Infarction. Donald E. Yochem, M.D., and Darrell E. Roach, Ph.D., Columbus 419

Allergic Bronchopulmonary Aspergillosis. An Unusual Clinical Presentation. Michael S. Kreindler, M.D., and James I. Tennenbaum, M.D., Columbus 421

The Prevention of Pruritus Ani. Leon Goldman, M.D., Cincinnati 425

1974 Annual Meeting Reports

Presenting Members of The Council Elected at the Annual Meeting 432

The President's Address 435

Index to Actions on Resolutions 440

Proceedings of the House of Delegates 442

Attendance of Delegates 460

Citation for Distinguished Service to Medicine .. 462

Proceedings of The Council 463

Details on Annual Meeting Attendance 464

Woman's Auxiliary Report to the House of Delegates 466

Roster of Committees Appointed for the Year, OSMA Officers, Executive Staff and AMA Delegates and Alternates 477

Medical Education

Does Ohio Need More Medical Education Facilities? 404

Workman's Compensation

Ohio's New Workmen's Compensation Law and How It Works 410

Family Physicians

24th Annual Scientific Assembly, Ohio Academy of Family Physicians 408

Medical Political Action

3,500 Reasons Why You Should Be a Member of OMPAC 441

County Medical Societies

Updated Roster of Ohio County Medical Society Officers and Meeting Dates 474

Woman's Auxiliary

Woman's Auxiliary Highlights and Reports of Annual Meeting 470

New Address

New Address for OSMA and The Journal 467

Other Features

'Know Your Limit' Slogan Highlights New Tact in Highway Safety Program 400

Keeping Up: Continuing Medical Education Courses for Physicians in Ohio 414

Obituaries 468

U. S. Adds 9,845 Physicians 472

OSMA Group Insurance Administrator Opens Cleveland Office 472

The Journal

Index to The Journal's Advertiser's in This Issue 480

Classified Advertisements 481

FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
10 SHATTUCK STREET
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Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

You should be aware of the possibility of side effects in some patients and should consult the complete product information before prescribing.

THE FRANCIS A. COUNTWAY
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JUL 29 1974

ROCHE
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Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 100.

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(diazepam)

To help you manage excessive psychic tension

The Ohio State MEDICAL JOURNAL

VOL. 70 JULY, 1974 No. 7

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Published monthly under the direction of The Council for ond by members of The Ohio Stote Medical Associotion, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with o definite membership for scientifc ond educotonol purposes.

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Entered os second closs matter July 5, 1905, ot the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptonce for moiling at special rote of postoge provlded for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Closs Postoge Poid at Athens, Ohio.

The Journol does not ossume responsibility for opinions expressed by the essayists. Advertiser must conform to policies and regulotions established by The Council of the Ohio Stote Medicol Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

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'Know Your Limit' Slogan Highlights New Tact on Highway Safety Program

A campaign to get Ohioans to KNOW YOUR LIMIT when drinking before driving is in progress, according to the directors of the Ohio Departments of Health, Highway Safety, Liquor Control and Transportation.

The four department directors (Health, Highway Safety, Liquor Control and Transportation) say the effort is designed to help adult Ohioans learn how much alcohol they can drink, according to body weight, before becoming dangerous drivers.

Noting that this is a revolutionary departure from the usual highway safety adage, "If you drink, don't drive," Frederick A. Vierow, Acting Highway Safety Director, said, "Prohibition was tried and it didn't work."

"We have to face the fact that 80 percent of adult Americans drink, and most of them also drive," Vierow commented. "It is time to educate ourselves about how much alcohol can be safely consumed before driving ability is impaired."

The campaign will include distribution of three million KNOW YOUR LIMIT cards (with blood alcohol content calculated to body weight) throughout the state, through state liquor stores, deputy registrars, and private company and government pay envelopes.

Contributing Patients' Names to Mailing Lists Is Illegal

A recent article in the *Wall Street Journal* states that many physicians are cooperating with mailing-list brokers in furnishing them lists of certain of their patients. Specifically, the article states that some 18,000 physicians throughout the nation are furnishing names of pregnant women, with data that would be useful to sellers of nursery supplies and related products. The article makes it clear that physicians receive no compensation for such service, but do it supposedly in the interest of their patients.

The article has been called to the attention of the Attorney General with the suggestion that an investigation be made as to whether the practice exists in Ohio.

In response to the article and certain other communications on the subject, William J. Lee, Administrator of the State Medical Board of Ohio, stated emphatically that "such release of medical information is contrary to the Medical Practice Act."

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Cleveland and Columbus October 30, 1974

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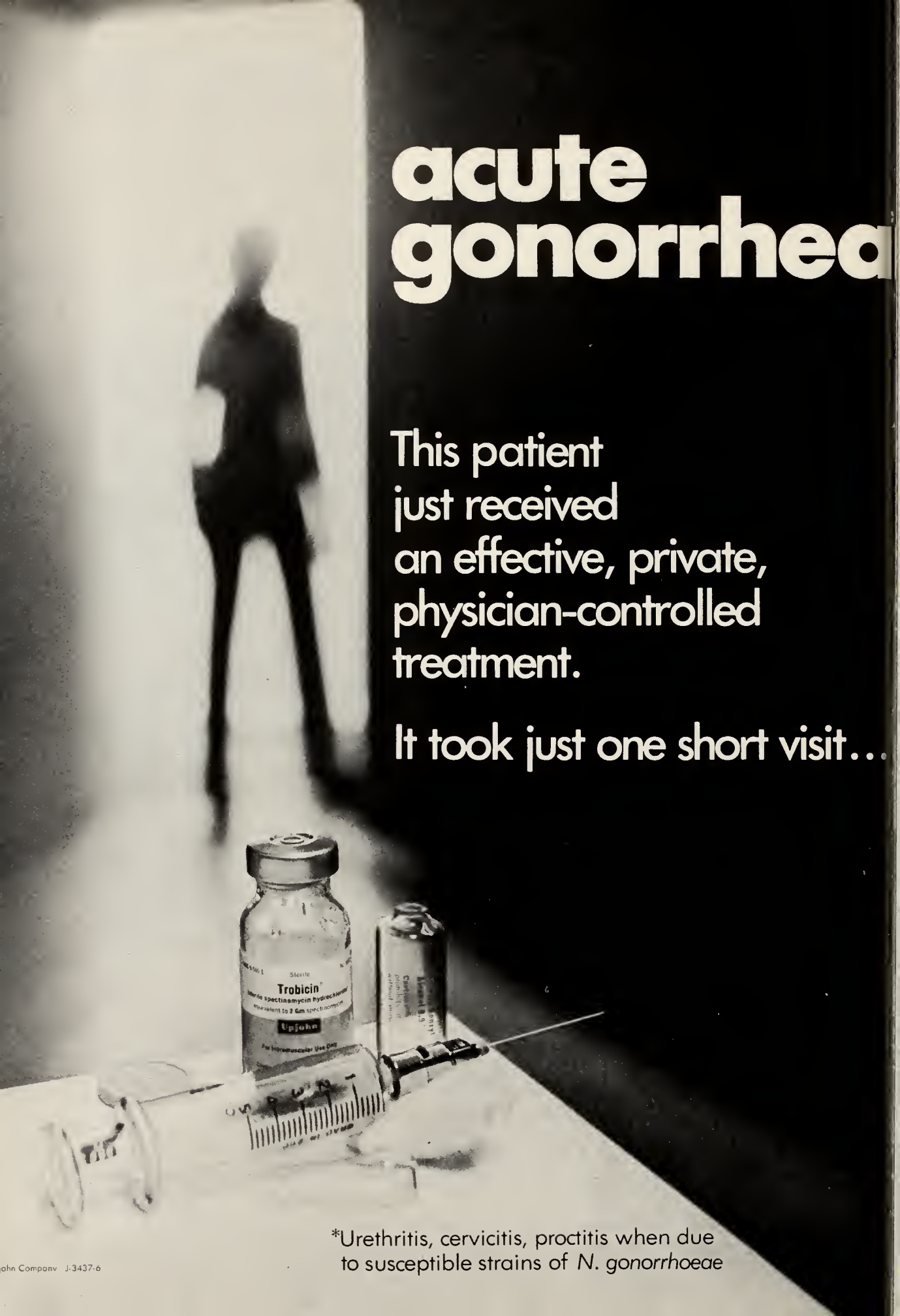
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acute gonorrhea

This patient
just received
an effective, private,
physician-controlled
treatment.

It took just one short visit...



*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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sterile spectinomycin hydrochloride

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2 gm vials containing 5 ml when recanstituted with diluent
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An aminacyclital antibiatic active *in vitro* against mast strains af *Neisseria ganarrhaeae* (MIC 7.5 ta 20 mcg/ml). Definitive *in vitra* studies have shawn no crass resistance af *N. ganarrhoeae* between spectinamycin and penicillin.

Indications: Acute ganorrheal urethritis and proctitis in the male and acute ganarrheal cervicitis and practitis in the female when due ta susceptible strains of *N. ganorrhaeae*.

Contraindications: Contraindicated in patients previausly faund hypersensitive ta spectinamycin.

Warnings: Nat indicated for the treatment of syphilis. Antibiatics used ta treat ganorrhea may mask ar delay the symptams af incubating syphilis. Patients should be carefully examined and manthly serological fallaw-up far at least 3 manths shauld be instituted if the diognosis af syphilis is suspected.
Safety far use in infants, children and pregnant wamen has nat been established.

Precautions: The usual precautions shauld be abserved with atapic individuals.
Clinical effectiveness shauld be manitared ta detect evidence af development of resistance by *N. ganorrhoeae*.

Adverse reactions: The fallawing reactions were observed during the single-dase clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insamnia.
During multiple-dose subchranic talerance studies in normal human volunteers, the fallawing were nated: a decrease in hemaglabin, hematacrit and creatinine clearance; elevatian af alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in narmal valunteers, a reductian in urine autput was nated. Extensive renal functian studies demanstrated na cansistent chonges indicative af renal taxicity.

Dosage and administration: Keep at 25° C and use within 24 haurs after recanstitution with diluent.

Male—Inject 5 ml intramuscularly far a 2 gram dase. Patients with ganarrheal practitis and patients being re-treated after failure af previaus antibiatic therapy shauld receive 4 grams (10 ml). In geagraphic areas where antibiatic resistance is knawn to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—Inject 10 ml intramuscularly for a 4 gram dase.

How supplied: *Viols, 2 and 4 grams—with ampaule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9%* w/v. Recanstitutian yields 5 and 10 ml respectively with a concentration af 400 mg spectinamycin per ml (as the hydrachloride). Far intramuscular use only.
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† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

Does Ohio need more medical education facilities?

Quoted from The Plain Dealer, Cleveland, April 30, 1974

No: Need is for a new system

By Howard D. Sirak

Let me state at the outset that I speak only as a citizen and a doctor interested in improving health care for the people of Ohio. My opinions are derived from my experience as a practicing surgeon, as a former professor of surgery and from knowledge acquired while serving on the Governor's Health Task Force.

Some may claim that my opposition to two new, state-supported medical schools is prompted by protectionist motives stemming from my long association with Ohio State University. Nothing could be further from fact. Actually, if the recommendations of the task force were adopted, the already existing four medical schools would have to assume a greater teaching and administrative burden.

What are the most serious health delivery problems?

First is the inadequate geographic distribution of our doctors. We have sufficient numbers in some portions of our larger cities, but we are woefully undermanned in rural and inner city areas.

Second, we need to increase the number of family-practitioner types of doctors. We are overproduced in many of the specialties.

The third is essential to the other two: We must train more nurses, physician assistants and medical technicians to help the family practitioner. It is unrealistic to expect to attract a physician to medically deprived areas if he isn't given the necessary help that he sees his colleagues receiving elsewhere.

If one accepts the foregoing as three of the most important aspects of health care requiring resolution, then one must ask: How can merely building new medical schools to increase the supply of young doctors satisfy all the other needs?

Currently, Ohio graduates about 620 doctors every year from its four medical schools. By 1980, these same four (at the present rate of expansion) would be producing about 750 graduates per year. Studies have shown that about 55% of these graduates leave the state. Thus, only about 280 of our 620 graduates stay in Ohio. Because each graduate costs about $60,000 to educate, each of our graduates who remains here to practice costs the taxpayer about $130,000. Pertinent to this is the fact that for every three doctors who receive only their medical education in Ohio, only one will remain to practice. However, for every three who take both their medical education and their hospital training (residency) in the state, two will stay to practice. It is obvious that the advantage lies not with simply having more medical students (where we have to graduate two to keep one), but with keeping more of our graduates here.

Simple arithmetic will demonstrate that so long as we continue to lose half of our medical school graduates, efforts directed solely at increasing their number are not only most expensive, but will have very little impact on the number of practitioners, on the nature of their practice and on where they locate.

The task force has proposed creating a system that will be responsible for developing family-practice education programs in the medical schools which utilize the many smaller community hospitals throughout the state for residency training in this "specialty." These family-practice training programs would be of high quality so as to be attractive to our medical graduates. The young doctors, being introduced to the communities that need them during their training years, would be more inclined to remain there. The very necessary expansion of the medical assistant training would be included.

To avoid the expensive duplication of the undergraduate basic medical science teaching staffs and administrative personnel, the task force recommended that these programs be supervised by one of the four medical schools through locally situated members of their staff.

Ohio needs a system like those operating successfully in some other states that will deal with all aspects of the health-delivery problem. Our tax dollars are limited. We must spend them wisely.

Dr. Sirak was a member of the Governor's Task Force on Health Care, which recommended against new medical schools in northeast Ohio and at Dayton. He has been a Professor of Surgery at the Ohio State University, where he is a trustee. He is on the staffs of Children's and University hospitals in Columbus.

Yes: We have fallen behind

By Stanley W. Olson

Information current to 1972 shows that the United States has 325,789 M.D.s, or 157 per 100,000 population; Ohio has 14,848 M.D.s, or 137 per 100,000 population; northeastern Ohio (the 17 county region exclusive of Cuyahoga and Lorain counties) has 2,652 M.D.s, or 104 per 100,000 population.

Thus, Ohio has 12% less M.D.s than the U.S. average, while northeastern Ohio has 24% less M.D.s than the Ohio average and 33% less than the United States as a whole.

The United States admitted 13,726 first-year medical students to all its medical schools; Ohio admitted 548 first-year students to its four medical schools. The United States has 6.66 first-year medical school admissions per 100,000 population, Ohio 5.07 per 100,000.

Thus, Ohio admitted 24% less first-year students than the U.S. average.

The United States has 32% of its graduate training programs filled by foreign medical graduates, Ohio 46% and northeastern Ohio 60%.

From 1950 to 1972, all Ohio medical schools graduated a total of 6,639 M.D.s. In that same period about 4,600 Ohio physicians died and had to be replaced by new graduates. The output of the schools thus represented a net gain of about 2,000 additional M.D.s Increase in the number of M.D.s in Ohio from 1950 to 1972 was 5,095 (from 9,753 to 14,848), meaning that about 3,100 were produced by the other medical schools of the United States or of foreign countries to fill Ohio's needs, or 47% more than Ohio actually produced in its own schools.

Despite these statistics and actions by the General Assembly to create new medical education facilities in Ohio, controversy over the need continues.

This situation exists, in part, because the report of the Governor's Task Force on Health Care, which was issued in draft form in November, 1973, recommended support of clinical training for graduate M.D.s (internship and specialty training) but opposed support for new medical schools in northeastern Ohio and at Dayton.

Governor Gilligan has every reason to wish to assure himself that the establishment of new medical schools is both necessary and in the best interest of the people of the State of Ohio. Medical education is an expensive undertaking. If reasonable alternatives exist they should surely be identified. It is my view that the data that were presented and reviewed by the task force failed to recognize the extent to which Ohio medical schools had fallen behind in the production of physicians to meet the demands of the people for more medical care. The fact that Ohio still has 12% fewer physicians than the rest of the United States suggests that those demands are not unreasonable.

The ability of hospitals to maintain appropriate standards for the accreditation of internship and residency training programs has become increasingly dependent upon a close affiliation with an approved medical school. Community hospitals in northeastern Ohio represent a substantial continuing investment on the part of local citizens who have frequently and generously supported building and facilities expansion drives.

However, these hospitals, outside of the Cleveland metropolitan area, have had difficulty establishing relationships with existing medical schools. In the past five years, internship and residency programs have been discontinued at major hospitals in Warren and Canton. Hospitals in Akron, Canton, and Youngstown support the establishment of the new medical school because it will afford them the opportunity for a meaningful medical school affiliation and will strengthen their graduate training programs and their ability to deliver high quality patient care.

The Northeastern Ohio Universities College of Medicine plans to accept students, after graduation from high school, into a six-year combined Bachelor of Science-Doctor of Medicine degree program beginning in the fall of 1975. These students will be ready for three years of intensive clinical experience in 1978. Prior to that date, the college will work closely with community hospitals throughout the region to strengthen internship and residency programs as a necessary step to assure the quality of the undergraduate educational experience of its medical students. The new medical school in northeastern Ohio proposes to carry out the clinical training of students in these existing major community hospitals. The college will not undertake the building of an expensive new university teaching hospital.

Case Western Reserve University School of Medicine is an outstanding institution which, together with the Cleveland Clinic, establishes Cleveland as a major medical referral center. The Northeastern Ohio Universities College of Medicine does not plan to duplicate these valuable health care resources, but to supplement their efforts by strengthening the regional health care institutions in northeastern Ohio. We plan to place substantial, but by no means exclusive, emphasis on primary care and family medicine.

At a time when only one of three qualified applicants can be admitted to a medical school, when Ohio depends on other U.S. and foreign medical schools to make up its deficit, and when northeastern Ohio hospitals urgently need a medical school affiliation to strengthen their training programs and need training programs to attract more physicians to the region, positive action is required.

Dr. Olson is Provost and Acting Dean of the Northeastern Ohio Universities College of Medicine, established last year by the General Assembly to plan a new medical education program in this area.

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24th Annual Scientific Assembly Ohio Academy of Family Physicians

THE Ohio Academy of Family Physicians will hold its 24th Annual Scientific Assembly at the Cleveland Plaza Hotel, Friday, Saturday and Sunday, August 9, 10 and 11. Additional information may be obtained from the Ohio Academy of Family Physicians, 4075 N. High Street, Columbus 43214.

The program, beginning at 1:00 p.m. Friday, has been announced as follows:

How to Clinic . . .

Joint Injection—Arthur L. Scherbel, M.D., Cleveland

Gyn Techniques—James Kreiger, M.D., Cleveland

Casts—H. Royer Collins, M.D., Cleveland

Needle Biopsy—Anthony L. Lalli, M.D., Cleveland
(3:00 p.m. break to view exhibits)

Arterial Puncture—Avram M. Cooperman, M.D., Cleveland

IPPB, Home Use—Joseph F. Tomashefski, M.D., Cleveland

Exercise Testing in Coronary Atherosclerotic Heart Disease—Wayne Siegel, M.D., Cleveland

Saturday, August 10

Clinical Sessions:

Management of Vertigo—Edward L. Hendershot, M.D., Cleveland

Facts and Fantasies of Good Nutrition—Lawrence Power, M.D., Detroit

Are Annual Physical Exams Necessary?—William A. Stowe, M.D., Dayton

Anaerobic Infections—Martin C. McHenry, M.D., Cleveland

Paramedics' Role in Modern Medicine—Edward K. Yantes, M.D., Wilmington

Chemotherapy Monitoring and Choice—Carl W. Groppe, Jr., M.D., Cleveland

Problem Oriented Medical Records—Fred V. Light, M.D., Cleveland

GU Infections—Leonard B. Berman, M.D., Cleveland

Coronary Angiography, When Is it Indicated?—Joseph Edelstein, M.D., Cleveland

Management of Neck Pain—John S. Collis, M.D., Cleveland

Team Approach to Breast Cancer—
George Crile, Jr., M.D., Cleveland; John Peter Minton, M.D., Columbus; Laurence J. Fahey, M.D., Columbus; Carl W. Groppe, Jr., M.D., Cleveland; and Walter A. Holbrook, M.D., Worthington

Antibiotics of Choice for Serious Infections Caused by Aerobic Bacteria—
Martin C. McHenry, M.D., Cleveland

Heart Disease Panel—
Moderator—Douglas P. Longenecker, M.D., Columbus, Family Physician

Surgical Viewpoint—Donald B. Effler, M.D., Cleveland

Nonsurgical Viewpoint—Mark Silverman, M.D., Atlanta

Nutrition in Heart Disease—Lawrence Power, M.D., Detroit

Exercise Program and Testing—Wayne Siegel, M.D., Cleveland

Sunday Morning, August 11

Repeat of Clinical Sessions—same as Saturday schedule

Psychiatric Session—

Drug Abuse and Alcoholism in Our Time—LeClair Bissell, M.D., New York

How to Get Rid of Sex Hangups—Elizabeth Wales, Ph.D., Cincinnati

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In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Ohio's New Workmen's Compensation Law and How It Works

THE FINAL REVISIONS of H.B. 417 which expands the Ohio Workmen's Compensation Law goes into effect July 1, 1974. Physicians, as employers, employees, and as examiners of potential recipients of benefits, will wish to acquaint themselves with new provisions of the law.

A brochure entitled "Here's how the new Workmen's Compensation Law works for you," prepared by the Ohio Workmen's Compensation Bureau has been mailed to all members of the Ohio State Medical Association.

Following is a summary of provisions of the law with references to sections of the Ohio Revised Code in which these provisions are covered.

Coverage. The act expands the coverage of the Workmen's Compensation Law from employers with three or more employees to those with one or more employees. It eliminates the specific exclusions of domestic help and casual workers and requires coverage for any such persons who earn $50 or more from any one household in a calendar year. The act also permits employers who are sole proprietors of partners to cover themselves for the purposes of workmen's compensation by giving written notice to the Bureau of Workmen's Compensation and listing their compensation. The expanded coverage of the act is delayed until July 1, 1974.

Workmen's compensation coverage is further extended to persons other than volunteer firemen or policemen, who can already be covered, engaged in emergency service at the request of any governmental agency or duly constituted public official. Costs associated with any benefits to these persons are to be charged to the state surplus fund.

Weekly Benefits. The act changes the maximum and weekly benefits as follows:

Temporary total disability: The maximum benefit for temporary total disability is changed from $77 to 66⅔ percent of the statewide average wage or an individual's full wage if less than the minimum. Eliminated from the law is the provision that, for the first 12 weeks of disability, the maximum weekly benefit is to be $84. Also eliminated is the ceiling of $10,750 formerly imposed on such payments.

Permanent total disability: The maximum benefit for permanent total disability is changed from $77 to 66⅔ percent of the statewide average weekly wage; the minimum benefit is changed from $49 to 50 percent of the statewide average weekly wage. The act redefines the physical loss of both hands, both arms, both feet, both legs, both eyes, or any two thereof to include loss of use as a condition constituting permanent total disability and stipulates that the permanent total compensation payable for such a loss is additional to any scheduled loss liability.

Temporary partial disability: The act changes the maximum award for temporary partial disability, previously set at 66⅔ percent of the impairment of an individual's earning capacity but not in the excess of $70, to 66⅔ of the statewide average weekly wage.

The maximum public work-relief benefits payable are increased from $18.75 to $32 per week.

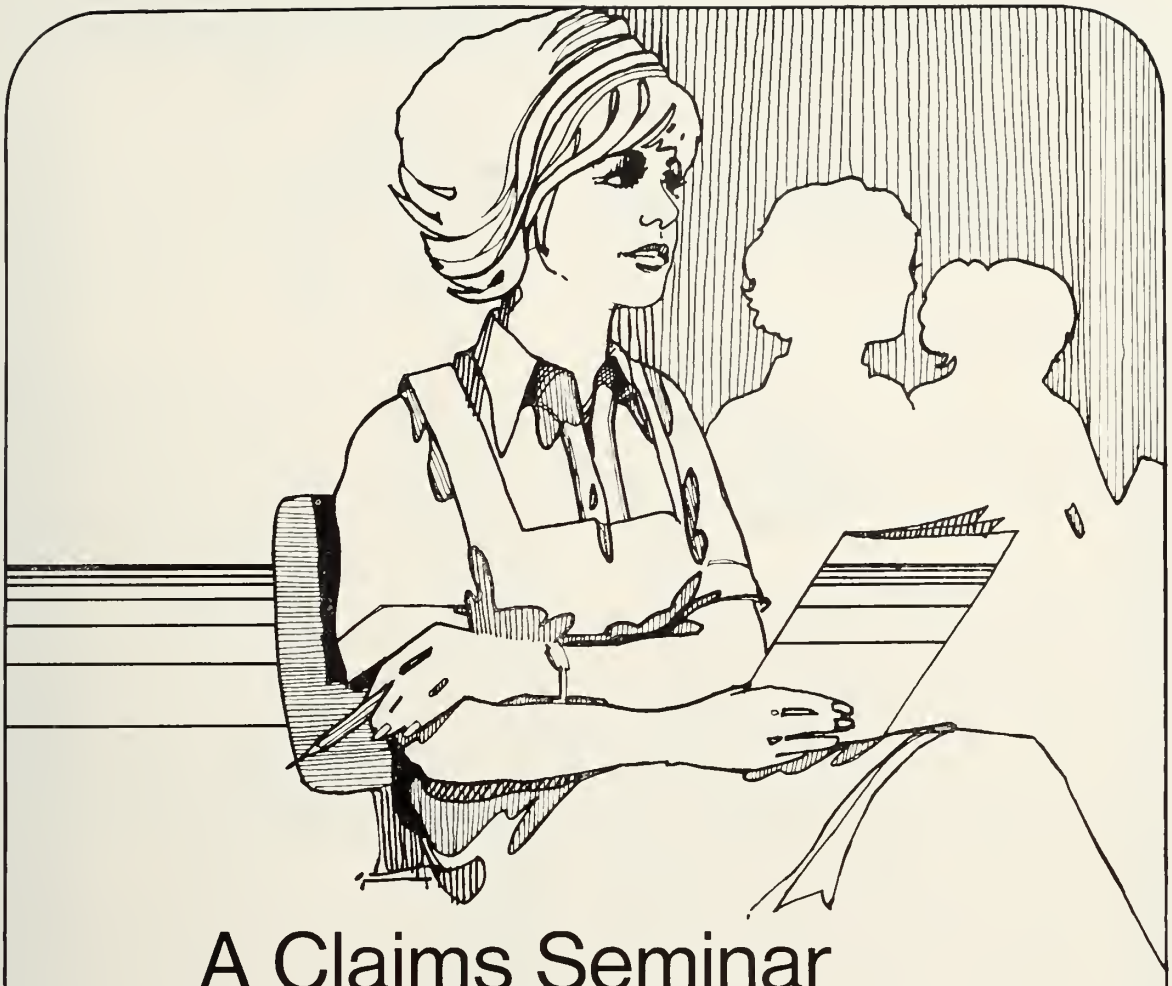
Funeral expenses. The maximum amount of funeral expenses payable by the Industrial Commission for a death due to injury or occupational disease is increased from $750 to $1,200.

Scheduled loss disabilities. In determining an individual's eligibility for benefits, the loss of use of two or more fingers is to be considered equivalent to the actual physical loss of the fingers. The standard for determining eligibility on account of ankylosis (stiffness of joints) is relaxed.

Hearing aids. The act requires the Industrial Commission to pay for the repair or replacement of hearing aids whenever the need for such aids arises from an occupational disease or injury.

Death benefit dependency awards. The maximum weekly death benefit award to dependent persons is increased to 66⅔ percent of the statewide average weekly wage. A floor of not less than 50 percent is placed under that figure only in the case of wholly dependent persons. The act removes the lid of $21,000, plus $1,000 per dependent child and spouse up to $3,000, on the total award which may be granted to wholly dependent persons and the lid of $17,000 on the total award for partly dependent persons.

Dependent awards are to continue until the death or remarriage of the dependent spouse. If the spouse remarries, he is to receive a final, lump sum settlement equivalent to two years' benefits. In the case of children, death benefit awards are to run until the child reaches eighteen years of age, twenty-five years if he is a full-time student in an accredited educational institution, or as long



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as his handicap remains if he is mentally or physically incapacitated.

Maximum weekly benefit escalator. Effective July 1, 1974 and each July 1 thereafter, the maximum weekly benefit (except for permanent partial disability compensation and except for the Disabled Workmen's Relief fund, which is based on the Consumer Price Index) is to be based on the "statewide average weekly wage." The statewide average weekly wage is to be based on the annual earnings of all persons covered by unemployment compensation and is to be calculated as of April 1 of the calendar year preceding July 1.

Penalty award. If a minor who is illegally employed is injured, he is to be awarded 100 percent more than the maximum award established under law, with the cost payable by the employer involved.

Vocational rehabilitation. The maximum weekly maintenance payment available to persons undergoing vocational rehabilitation under the sponsorship of the Bureau of Workmen's Compensation is increased to $84. Also the annual sum the bureau is required to transfer from the state insurance fund to the Rehabilitation Services Commission for training under state and federal vocational rehabilitation training programs is increased from $80,000 to $200,000.

Permanent partial disability. The act makes an injured worker eligible to apply to the Industrial Commission for a determination of his percentage of permanent partial disability 40 weeks after the end of his first period of temporary total disability or 40 weeks after the injury or occupational disease occurred, if no temporary total disability compensation is paid to him.

Occupational diseases. The act makes cardiovascular and pulmonary diseases of paid or volunteer policemen an occupational disease compensable in the same manner as such diseases are compensable for firefighters. It also designates asbestosis as an occupational disease and applies to all individuals afflicted with it the same benefits and requirements applied to an individual afflicted with "black lung" or silicosis. The act further eliminates the exclusion of berylliosis from the general provisions relating to the compensation of individuals with occupational diseases of the respiratory tract resulting from injurious exposures to dust.

Change-of-occupation payments are authorized for persons who contract asbestosis. These payments are to amount to $49 per week for 30 weeks and 66⅔ percent of the wage loss suffered by the change (up to a maximum of $40.25 per week) for a further 100 weeks. In the case of firefighters, the additional award is for 75 weeks. The act also enables policemen who contract cardiovascular or pulmonary ailments to receive the same change-of-occupation benefits which firefighters have been receiving.

Penalties. The act eliminates the penalty for the failure of a physician to report his diagnosis of an occupational disease. It also adds 30-day jail sentences to the maximum penalties levied on an employee of the Industrial Commission who divulges information and on an employer who fails to report an injury.

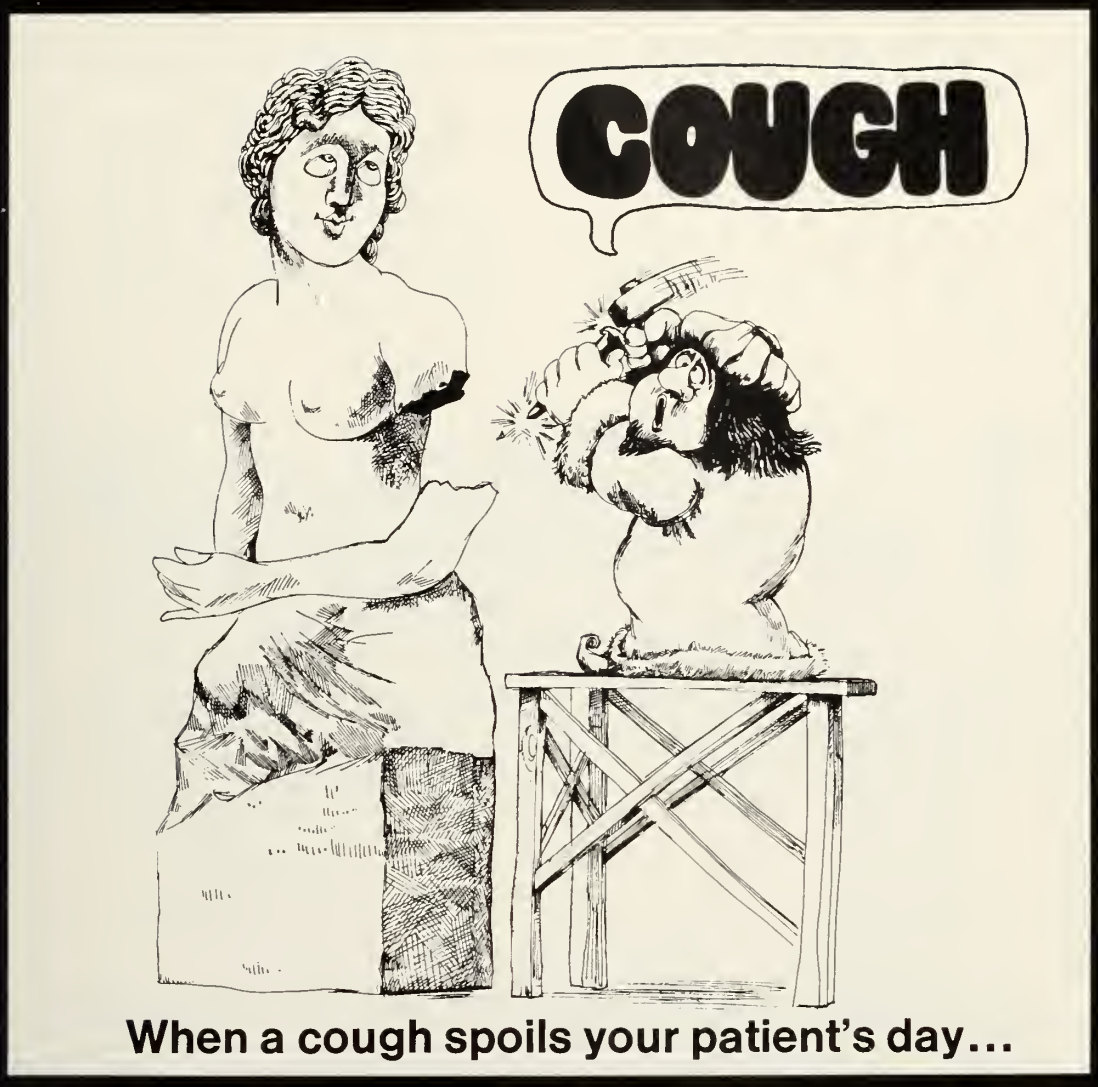
Other. The act authorizes the Administrator of the Bureau of Workmen's Compensation, when in the best interests of the insured, to issue written binders on new coverage under workmen's compensation upon submission of a request for coverage by an employer. A binder is to remain in effect for 30 days from the date of issue and may not be renewed. Payroll reports and premium charges are to coincide with the effective date.

Authorization is granted to the administrator to levy a minimum annual administrative charge on employers whose payroll reports develop income that is inadequate to cover administrative processing costs. The act also authorizes payment for medical services to be made from the statutory surplus on behalf of the injured worker of a self-insuring employer who has defaulted on his obligations.

The act removes the provision that if an employer acknowledges to the administrator the validity of a claim, the administrator may investigate and make an award without any necessity for the employee to fill out a claim form. Other changes in procedural requirements are also made in the law.

The reader is referred to the following sections of the Ohio Revised Code for additional information: Secs. 4121.212, 4123.01, 4123.025, 4123.22, 4123.26, 4123.32, 4123.512, 4123.56 to 4123.59, 4123.62, 4123.66, 4123.68, 4123.75, 4123.89, 4123.99, and 4127.04.

Separations from the U.S. armed forces during April pushed the number of living veterans of the Vietnam era to 7,002,000, the VA reported. The total number of living veterans went to 29,233,000, including 1,465 who served during the Spanish-American War. There are 13.8 million living veterans of World War II with an average age of 54, and 1.1 million of World War I with an average age of 79.



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Continuing Education Opportunities for Physicians in Ohio

July

Association of Physicians of the State of Ohio—Quarterly meeting and program, July 12, Massillon State Hospital; contact Virginia S. Edwards, M.D., Secretary-Treasurer, 347 Lexington Ave., Mansfield 44907.

August

Ohio Academy of Family Physicians Annual Scientific Assembly—Cleveland Plaza Hotel, August 8-11; contact Mrs. Florence Landis, Executive Director, Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214.

September

Pediatrics and the Practicing Physician —Symposium sponsored by the Medical College of Ohio at Toledo and the Toledo Pediatric Society, Sept. 20-22, at Sheraton Westgate, Toledo. For additional information, write: Howard S. Madigan, M.D., MCO, P. O. Box 6190, Toledo 43614.

Third Teaching Skills Workshop, sponsored by the OAFP at the Imperial House North, Morse Road at I-71, Columbus, Sept. 27-28; contact Mrs. Florence Landis, Executive Director, Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214.

October

American Association for Laboratory Animal Science—25th Annual Meeting, Cincinnati Convention-Exposition Center, Cincinnati, Oct. 21-25; contact: Executive Secretary Joseph J. Garvey, AALAS, 2317 W. Jefferson St., Suite 208, Joliet, Illinois 60435.

Reye's Syndrome—Sponsored by the Children's Hospital Research Foundation; at the Neil House, Columbus, Oct. 29-30; contact: J. Dennis Pollack, Ph.D., 215 Ross Hall, The Children's Hospital, 561 South 17th St., Columbus 43205.

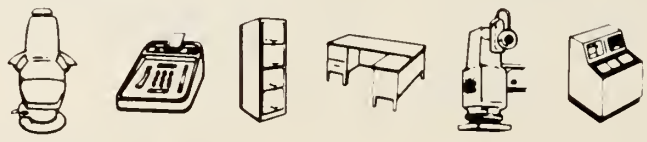
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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare



A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it, for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the necessity

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company



A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year.

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It

fr a package insert in many in-
s nces. This would constitute a
s bstantial saving for the manu-
f turer.

By a complete compendium, I
o not mean a volume of prohibi-
t e size. You don't need a book
d scribing 25,000 products with
a enormous amount of repetition.
R ther, drugs should be arranged
b class. Mutually applicable infor-
m tion would be provided, along
w h brief discussions pinpointing
d ferences in specific drugs of
t t class. Listings would be cross-
i lexed in a useful way.

O her Available Documents as S urces of Information

Existing references such as P R and the AMA Drug Evaluation a obviously useful but they are i omplete. Either they are not c ss-referenced by generic name a d do not group drugs with simi- a characteristics, or they do not i all the available and legally m rketed drugs. And some of t se omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

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s ould in no way imply control over t e practitioner's prerogatives.

W y Another Compendium?

A practicable, single-volume c mpendium cannot, nor is it n cessary to, include all drugs on t e market today. From my prac- t e of internal medicine for some 1 years, my experience as a con- s tant, and as a faculty member o four or five medical schools, I w uld estimate that a doctor uses o y 30 to 35 drugs regularly. The 1 72 Physicians' Desk Reference, i identally, contained about 2 00 entries.

As to whether there should be a ederal compendium, in my opin- i , as stated earlier, the answer is e sy—there should *not* be one. The p posal assumes that existing c mpendia are inadequate. We're n t sure of that at all. Whatever its i perfections, the present drug i ormation system in the U.S. is o en, multifaceted, pluralistic and e ensive. Good compendia exist, a well as other ample sources on d g therapy, ranging from journal l erature through AMA Drug Evalu- a on to company materials. Not a physicians may use such s urces as often or as well as they s uld, but that is the fault of the m n, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

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In Vitro Thrombosis in Acute Myocardial Infarction

Donald E. Yochem, M.D.
Darrell E. Roach, Ph.D.

ARDLIE, ET AL[1] MEASURED the length and weight of in vitro thrombi in myocardial infarction (MI) but did *not* determine the thrombus formation time (TFT). Rozenberg[2] studied the rate of in vitro thrombus formation in MI but the patients had recovered from six weeks to 12 months prior to the study and, therefore, were *not* patients with acute myocardial infarction (AMI).

The purpose of this study was to determine whether the in vitro TFT would be significantly shorter in AMI patients than in control subjects.

Patients and Methods

Patients.—The TFT was determined in 52 documented AMI patients admitted to the Coronary Care Unit (CCU) of the Blanchard Valley Hospital, Findlay, Ohio. Ages ranged from 43 to 70 years with a mean age of 59 years. Criteria for infarction were history, electrocardiogram (ECG) evidence of infarction, and characteristic changes in the values of creatine phosphokinase (CPK), serum glutamic oxaloacetic transaminase (SGOT), and lactic dehydrogenase (LDH).

Control Subjects.—The TFT was also determined in 89 volunteer control subjects, matched as closely as possible for age and sex with the AMI group. Ages ranged from 34 to 65 years with a mean age of 55 years. These controls were regular employees of the Marathon Oil Company and had a negative history of coronary heart disease (CHD) without clinical or ECG evidence of myocardial infarction. Ardlie, et al[1] and Rozenberg[2] also used comparable control subjects in their studies.

TFT Determinations.—A free-flowing venous blood sample was obtained when the patient entered the CCU; and the TFT of the patients and control subjects was determined within *five minutes* after the blood was withdrawn. All determinations were made at the Blanchard Valley Hospital. Patients receiving anticoagulant therapy were not tested. Samples were obtained with 12-ml disposable plastic syringes and 20-gauge disposable sterile needles.

To avoid possible contamination of the sample with tissue thromboplastin, free-flowing venous blood was obtained, the needle was removed, and the first part of the sample was removed for routine tests. Then 2.25 ml for a TFT determination was transferred to a siliconized test tube containing 3.8 percent trisodium citrate anticoagulant. All procedures were performed promptly after the blood was withdrawn.

The TFT (also termed TCT, thrombotic coagulation time) was determined with an improved Chandler method previously described by Yochem.[3] This highly reproducible method produces a typical platelet-head thrombus that resembles an in vivo arterial thrombus. The method also proved that the TFT varies in apparently healthy subjects; and although the method showed that aspirin increased the in vitro TFT in half the subjects tested,[4] it remains to be proven that this test might indicate hematological changes that could affect in vivo thrombosis.

Results

Table 1 shows the results of age matching for the AMI patients and control subjects. The mean age for the AMI patients is significantly

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This investigation was conducted under contract #4-0001 with the Blanchard Valley Hospital through a grant from the Marathon Oil Company.

Submitted September 28, 1973.

higher ($P < .01$) than the controls. This is entirely due to the inclusion of 12 patients over 65 years of age in the AMI group. However, if the over-age-65 cases are deleted from the AMI group, the mean age difference is reduced to one year, which is not significant statistically.

Table 2 shows there was no significant difference in the distribution by sex ($.95 > P > .90$) between the AMI patients and control subjects.

Additional analysis controlling on age and sex indicated that the TFT was significantly shorter in AMI patients than in control subjects for all age and sex groups.

The TFT values are shown in Table 3. The mean TFT in minutes and seconds was 2:58 for the AMI patients and 3:43 for the control subjects. This mean difference is highly significant, with a probability of a difference of this magnitude occurring by chance being less than one in a thousand. The analysis showed that 73.0 percent of the infarct patients had a TFT of less than 3:20 whereas only 21.3 percent of the control subjects had a time this short. At the other end of the distribution, only 7.7 percent of the infarct patients had a TFT of 4:00 or over compared to 29.2 percent of the controls.

It is noteworthy that the mean TFT (3:43) and standard deviation (0:32) for the control subjects used in this study are very close to the original base line study of 100 apparently healthy subjects reported by Yochem[3] (mean TFT 3:44 and standard deviation 0:25), although the mean age of the latter group was only 45 compared to 55 for the controls used in this study.

Table 1. Age Distribution of Acute Myocardial Infarction Patients and Control Subjects

Age	Infarct Group Number	%	Control Group Number	%
66-70	12	23.1	—	—
61-65	11	21.2	20	22.5
56-60	15	28.8	28	31.5
51-55	4	7.7	21	23.6
46-50	7	13.5	9	10.1
41-45	3	5.8	7	7.9
36-40	—	—	3	3.4
31-35	—	—	1	1.1
Totals	52	100.1	89	100.1

Table 2. Sex Distribution of Acute Myocardial Infarction Patients and Control Subjects

Sex	Infarct Group Number	%	Control Group Number	%
Males	37	71.2	65	73.0
Females	15	28.9	24	27.0
Totals	52	100.1	89	100.0

Table 3. Distribution of Thrombus Formation Time of Acute Myocardial Infarction Patients and Control Subjects

Thrombus Formation Time Minutes & Seconds	Infarct Group Number	%	Control Group Number	%
5:20-5:59	—	—	1	1.1
4:40-5:19	1	1.9	4	4.5
4:00-4:39	3	5.8	21	23.6
3:20-3:59	10	19.2	44	49.4
2:40-3:19	23	44.2	17	19.1
2:00-2:39	10	19.2	2	2.2
1:20-1:59	5	9.6	—	—
Totals	52	99.9	89	99.9
Mean	2:58		3:43	
Std. Dev.	0:43		0:32	
Range	1:30-5:00		2:18-5:28	
$t = 6.51$	$P < .001$			

Discussion

Chandler[5] first described an apparatus that produces an in vitro thrombus when recalcified venous whole blood flows in a rotated circular plastic tube. Other investigators[6,7] confirmed that his method produces a white platelet-head thrombus that morphologically resembles an in vivo arterial-type thrombus instead of a clot produced by static clotting methods. Although venous blood is used, it should be noted that adequate velocity of blood flow in the apparatus is necessary to produce an in vitro platelet-head thrombus.[5] Furthermore, Engleberg[7] stated that "the observed disparity between thrombus formation times and clotting times after smoking also emphasizes that thrombosis and coagulation are different, albeit related, processes."

Using a modified Chandler method, Ardlie, et al[1] found that thrombi after myocardial infarction were both longer and heavier than thrombi of control subjects. Although they did not determine the TFT, they stated that "the blood of patients with myocardial infarction shows a propensity to abnormal in vitro thrombosis and platelet aggregation."

Using a different method, Rozenberg[2] reported no significant difference in the rate of in vitro thrombus formation between healthy volunteers and patients who had recovered from MI six weeks to 12 months prior to the study. He indicated, however, that the blood sample might have been taken at the wrong time. In the present study, the TFT was determined when the AMI patient entered the CCU and not weeks or months later.

TFT Values and Implications.—The mean difference between the AMI patients and control subjects was highly significant (2:58 for AMI patients and 3:43 for controls ($P < .001$)). Also, a substantially greater proportion of the infarct

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patients showed a significantly short TFT, ie, less than 3:20. Furthermore, the TFT was considerably shorter in the AMI patients than in the control subjects for all age and sex groups.

Although the TFT was determined in AMI patients and an arterial platelet-head thrombus was produced, it should be emphasized that an in vitro technic was used. Therefore, the in vitro results are not necessarily analogous to in vivo events. Furthermore, it should be stated that infarction can occur without thrombosis.

We do not suggest that a significantly short TFT indicates a thrombotic tendency that might be a coronary "risk factor." Indeed, any changes in the TFT may occur after, instead of before, the AMI. Therefore, since we do not know if the TFT was the same before *and* after the acute infarction, a longitudinal study is necessary to evaluate a significantly short TFT. A longitudinal study could determine whether a group of apparently healthy subjects with a significantly short TFT subsequently have a higher incidence of AMI than those with a relatively long TFT. In the AMI patients, a TFT determination shortly after infarction would also indicate any TFT changes which might be related to the infarction.

Summary

The in vitro thrombus formation time (TFT) was determined in 52 patients with documented acute myocardial infarction (AMI) and 89 control subjects. The mean TFT in minutes and seconds was 2:58 for the AMI patients and 3:43 for the controls. This mean difference is highly significant ($P < .001$). Analysis showed that 73.0 percent of the infarct patients had a TFT of less than 3:20 whereas only 21.3 percent of the controls had a time this short. At the other end of the distribution, only 7.7 percent of the infarct patients had a TFT of 4:00 or over compared to 29.2 percent of the controls.

Since we do not know if the TFT was the same before *and* after the acute infarction, a longitudinal study is necessary to evaluate a significantly short TFT.

Acknowledgments: We acknowledge the cooperation of Chester Samuelson, M.D., Medical Director, Marathon Oil Company; the Hancock County Medical Society; and the Medical Staff, Blanchard Valley Hospital with Manuel Sarmina, M.D., Laboratory Director; Ronald Milbourn, Chief Technologist; the laboratory staff; and coronary care unit nurse, Joan Harding.

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Allergic Bronchopulmonary Aspergillosis

An Unusual Clinical Presentation

Michael S. Kreindler, M.D.
James I. Tennenbaum, M.D.

IN RECENT YEARS, many cases of allergic bronchopulmonary aspergillosis have been reported in England. More cases are being reported in the United States, but many physicians are still unfamiliar with the clinical features of this disease and fail to recognize it.

Allergic bronchopulmonary aspergillosis is a respiratory disease which has an immunologic pathogenesis and occurs solely in allergic asthmatic patients. It was first described in 1952 by Hinson and associates.[1] The characteristic clinical features of this disease include recurrent pulmonary infiltrates associated with sputum and peripheral blood eosinophilia, weight loss, low grade fever, and a cough productive of purulent sputum containing brownish-gold plugs, which on microscopic exami-

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Submitted December 6, 1973.

nation prove to be collections of mycelia of the common airborne fungus, *Aspergillus fumigatus*.

The diagnosis should be suspected in any asthmatic patient who presents with a history of "recurrent episodes of pneumonitis" associated with fever, cough and purulent sputum, a pulmonary infiltrate on chest x-ray, and episodic wheezing which requires steroids in addition to oral and aerosol bronchodilator therapy for control.

These patients typically have, on laboratory examination, leucocytosis often associated with marked peripheral blood eosinophilia, sputum smears loaded with eosinophils and fungal mycelia, which are positive for *A. fumigatus* on culture, and the presence of serum precipitins against the antigen on agar diffusion study. In addition to an immediate wheal and flare reaction on skin testing with *A. fumigatus* antigen, a positive Arthus skin test develops at the injection site four to six hours after the immediate skin reaction has subsided. Elevated levels of serum IgE greater than 6000 units per ml have been described by Patterson, et al[2] to be of diagnostic significance during the acute phase of pneumonitis associated with this disease. Characteristically, bronchograms reveal the presence of proximal bronchiectasis with sparing of the peripheral bronchioles.

From August 1970 until May 1973, we followed a young asthmatic woman with allergic bronchopulmonary aspergillosis, who had an unusual clinical presentation.

Case Report

This 24-year-old woman had a history of asthma and allergic rhinitis since age 4 years. Immunotherapy for four years as a child resulted in no significant improvement, however, her symptoms were adequately controlled with oral bronchodilators.

At age 16 years, after a routine chest roentgenogram, she was informed that she had a left lung abnormality but, to the best of her knowledge, no further evaluation was made. Over the next five years, her asthma attacks continued to be episodic except while temporarily living in Colorado where they were almost nonexistent. She moved to Columbus, Ohio in August 1970 and her asthma increased in severity to the point that she was hospitalized at the Ohio State University Hospitals in September, in severe status asthmaticus.

On that admission, she was fatigued and extremely dyspneic. Oral temperature was 37.7 C (99.8 F). Blood gases revealed a pCO_2 of 29 mm Hg, pO_2 of 60 mm Hg, serum pH 7.47, and oxygen saturation of 92 percent. Total leucocyte count was 10,500 per cu mm with 18 percent peripheral eosinophils. The chest x-ray film showed a left hilar abnormality, which was interpreted on admission as early pneumonia superimposed on an old granulomatous inflammatory process. This abnormality was noted on a chest x-ray film made one month prior to admission and later was thought to represent the same abnormality seen when she was 16 years of age. A gram stain of the sputum revealed many eosinophils with no predominant organism. Sputum cultures were negative for pathogenic bacteria, acid fast organisms, and fungi. Complement fixation and agglutination tests for histoplasmosis, skin tests for tuberculosis, and agar diffusion study for *Aspergillus* were negative. Serum electrolytes and chemistries were normal. She was treated for status asthmaticus and probable pneumonia with hydration, antibiotics, bronchodilators, and corticosteroids with excellent response. Skin testing prior to discharge indicated positive reactions to various mold spores, pollens, house dust, and animal danders, and a new program of immunotherapy was instituted.

Her asthma remained under control with oral bronchodilators except for occasional episodic wheezing and early morning cough. She continued immunotherapy for one year without noticeable improvement and then discontinued it.

From August to December 1971, she traveled abroad and had little problem with her asthma. She traveled through France where she worked in a vineyard as a grapepicker for several months. In November, while traveling along the coast of Morocco, her asthma worsened, complicated by acute bronchitis, and she returned home in December.

Her asthma improved over the next few months and, by February 1972, she was asymptomatic. A routine pre-employment chest x-ray film made on February 16, 1972 revealed a nodular infiltrate in the left upper lobe, and she was referred to the county board of health for tuberculosis evaluation which was negative.

From March until July 1972, she was seen frequently as an outpatient because of recurrent nodular and coalescent pulmonary infiltrates and asthma. She had no weight loss, fever, anorexia, or sputum production, although she continued to have early morning cough. Several complete blood counts during this period were normal except for peripheral eosinophil counts ranging between 8 and 11 percent which were thought to be compatible with her allergic asthma. Repeat skin tests for tuberculosis and histoplasmosis were negative.

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Serial chest roentgenograms revealed recurrent infiltrates in the right and left upper lobes and persistence of the left hilar abnormality seen on previous roetgenograms. Tests for Alpha 1-antitrypsin deficiency and serum immunoglobulin levels were normal. Pulmonary function studies revealed moderate-to-severe obstructive airway disease with considerable reversibility with bronchodilator therapy.

The recurrent infiltrates seemed to respond only to corticosteroid administration. suggesting that the patient had allergic bronchopulmonary aspergillosis or benign Loeffler's Syndrome. An *Aspergillus* skin test showed a positive immediate reaction but failed to produce a response after 6 and 24 hours. Precipitins for *Aspergillus fumigatus*, thermophilic actinomycetes, and all common mold antigens were negative both before and after concentrating the serum. Several sputum samples cultured for various fungi, including *A. fumigatus*, were also negative.

With intermittent courses of high-dose corticosteroid therapy, the pulmonary infiltrates were completely resolved by the end of June 1972. Her asthma was well controlled on oral bronchodilators and by July 1972, the steroids were discontinued.

In December 1972, the patient returned complaining of increased wheezing and cough productive of purulent sputum. She had no fever, chills. anorexia, or weight loss. Physical examination revealed decreased breath sounds over the upper left lung anteriorly with wheezing throughout both lungs. Total leucocyte count was 6650 per cu mm with 30 percent eosinophils. There was a new left-upper-lobe infiltrate seen on chest x-ray film. Steroids were restarted and hospitalization was recommended for further evaluation of the infiltrates and the eosinophilia, including bronchoscopy, bronchogram. and possible lung biopsy.

She was admitted to the Ohio State University Hospitals on January 16, 1973. Physical examination was normal except for scattered inspiratory and expiratory wheezes, which were more pronounced over the right lung. The admission electrolytes and serum chemistries were normal. Total eosinophil count was 1232 per cu mm. Serum protein electrophoresis was normal and an evaluation for collagen vascular disease including L.E. prep, antinuclear antibody, and rheumatoid factor was negative. Examinations of stools for ova and parasites were negative. A selective left bronchogram showed severe proximal bronchiectasis in the apical posterior, anterior, and superior lingular segmental bronchi of the left upper lobe with the peripheral bronchi being relatively normal. Bronchoscopy revealed increased secretions and a slightly stenotic appearing left upper lobe bronchus. Bronchial washings and brushings were negative for neoplastic cells and for acid-fast bacteria and fungi on examination and culture.

During a four-day hospital stay, she was afebrile and her asthma was under good control. Sputa were consistently negative for *Aspergillus*, thermophilic actinomycetes, and other common mold spores. The left upper lobe infiltrate resolved on high-dose steroid therapy, leaving only evidence of chronic inflammatory changes in the left hilum.

Steroids were discontinued after discharge, and her asthma has been well controlled on around-the-clock aminophylline therapy. Repeat chest roentgenograms have remained unchanged. A convalescent serum IgE level performed in April 1973 was 6500 units per ml, and serum precipitins for *Aspergillus fumigatus* were demonstrated by several laboratories, including our own, using freshly prepared aqueous extracts. These results finally supported the diagnosis of allergic bronchopulmonary aspergillosis.

Discussion

This patient lacked such diagnostic clinical and laboratory features as fever, weight loss, cough productive of purulent sputum, leucocytosis, positive sputum smears and cultures for *A. fumigatus*, and a positive Arthus skin test. The diagnosis of allergic bronchopulmonary aspergillosis was supported by the presence of recurrent pulmonary infiltrates and eosinophilia which responded well to steroid therapy, by positive serum precipitins against *A. fumigatus*, by markedly elevated serum IgE levels and by a classic bronchogram.[3] It is interesting to note that in this case serum precipitins were demonstrated only when different aqueous extracts of *A. fumigatus* antigen were utilized in agar diffusion studies. This, however, is not unusual in this disease because of the variable antigen production by the fungus. Since the use of a single antigen for diagnostic purposes might result in negative reactions, at least two extracts and perhaps more should be used for testing in order to obtain a positive result. This is especially true in patients with allergic bronchopulmonary aspergillosis.[4]

The pathogenesis of this immunologic respiratory disease results from both type I and type III immunologic mechanisms. The type I mechanism mediated through the reaginic or nonprecipitating-skin-sensitizing antibody of the IgE class is responsible for the immediate skin test reaction, the eosinophilia, the allergic asthma and an immediate positive bronchial challenge with a drop in forced expiratory volume upon inhalation of an aerosolized aqueous extract of *A. fumigatus*. The type III mechanism, mediated through a precipitating antibody of IgG or IgM class, is a complement-dependent reaction in which the forma-

tion of precipitating antigen-antibody complexes produce an inflammatory response that accounts for the Arthus skin reaction, and is thought to be partly responsible for the pulmonary infiltrates. The type III reaction also may account for a more severe, more prolonged asthmatic episode which develops about 8 to 12 hours after antigen inhalation and which is poorly reversed by inhaled or oral bronchodilators.[5]

The causative organism, *A. fumigatus,* a common airborne mold spore which is approximately 2 to 9 microns in diameter, is inhaled and, owing to its size, settles in the segmental bronchi and proximal bronchioles. The organisms become trapped in the asthmatic lung by bronchospasm and mucus secretions and grow in the excellent culture-like media. These mucus plugs which contain *Aspergillus* mycelia become lodged in the various segmental bronchi and bronchioles and provide a constant source of antigens to which precipitating antibodies are present in the blood stream. Antigen antibody reactions occur locally, and the microprecipitates of these antigen antibody complexes activate the complement system and produce an Arthus-type tissue-damaging reaction in the bronchial wall which results in tissue destruction and the characteristic proximal bronchiectasis seen on bronchograms in this disease. The consolidation which develops in the pulmonary segment beyond the plug may be an "eosinophilic pneumonia" capable of complete resolution. Both reaginic and precipitating antibodies are probably required for the development of the full picture of eosinophilia, pulmonary infiltrates, and the episodic wheezing associated with aspergillosis.[3] At the height of the antigenic stimulation when pulmonary infiltrates, eosinophilia and wheezing are present, serum IgE levels have been reported to rise to greater than 6000 units per ml and are considered to be diagnostic for this disease.[2]

Therapy in patients with allergic bronchopulmonary aspergillosis is aimed at either removing or destroying the mycelial plugs and hence eliminating the constant antigenic stimulation or by indirectly preventing the immunologic effects mediated by the organism's presence. Corticosteroids reduce the inflammatory reaction produced as a result of the complement-dependent type III immunologic mechanism. Their use is essential in controlling the severe, prolonged asthmatic episodes, in reducing the pulmonary infiltrates, and in preventing the destructive bronchiectasis. Oral bronchodilators, along with adequate hydration, are important in relieving bronchospasm and promoting expectoration of mucus in an effort to free mycelial plugs.

Recently, Slavin, et al have suggested the use of aerosolized amphotericin B in these patients in an effort to destroy the fungi within the bronchi. This method has resulted in a drop in precipitating antibody levels, thus bringing about a clearing up of the infiltrates and subsidence of the clinical symptoms.[6,7] Immunotherapy with mold extracts containing *A. fumigatus* is well tolerated by patients with allergic asthma induced by *A. fumigatus,* but not by those with allergic bronchopulmonary aspergillosis because of the development of an Arthus reaction at the injection site and the potential to produce a more prolonged and severe asthmatic attack hours after the injection.[4]

The difficulty experienced in this case illustrates how the finding of nodular, coalescing, pulmonary infiltrates in a chronic asthmatic might mislead one into diagnosing primary or secondary pneumonia, pulmonary granulomatous disease, or some other cause of pulmonary infiltrates associated with or without eosinophilia. However, allergic bronchopulmonary aspergillosis should be considered in the differential diagnosis. It has been reported in increasing numbers in the United States and may be more common than previously suspected.

Summary

We have presented this case with its unusual clinical presentation to alert physicians who care for asthmatic patients to have a high index of suspicion for this disease. The appropriate studies including multiple testing for serum precipitins with a number of different *A. fumigatus* extracts, skin testing for an Arthus response, the measurement of serum IgE levels, and bronchograms should be performed when the diagnosis is suspected, and early therapy with corticosteroids should be instituted so that complications of bronchiectasis and chronic obstructive pulmonary disease are prevented.

Acknowledgment: We extend our gratitude to Dr. R. Patterson, Northwestern University, for demonstrating *Aspergillus* serum precipitins and for performing quantitative serum IgE levels. In addition, we thank Dr. W. F. Hughes, Columbus, Ohio, for also demonstrating *Aspergillus* serum precipitins in this patient.

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The Prevention of Pruritus Ani

Leon Goldman, M.D.

A PREVENTION PROGRAM for the uncomfortable disorder of pruritus ani is usually not considered. This is so, not only for patients who have had recurrent minor episodes but even for those who have had severe and protracted difficulties. However, there are definite preventive measures which can be used in this multi-faceted disorder, secondary all the way from the enterobiasis (oxyuriasis) *Oxyuris* infestation in the child to the persistent disturbing perianal neurodermatitis of the businessman. Pruritus ani is more common in the adult male. Although textbooks[1,2] and articles[3] faithfully insist that pruritus ani is not a diagnosis but a symptom complex secondary to multiple causal factors, how extensive is the investigation after the all-too-casual inspection? Sometimes even inspection is not done under adequate lighting, nor is complete examination of the entire area always done. The proctologist can evaluate anatomic factors, such as hemorrhoids or hemorrhoidal tags. Local contact factors, local infections, or parasitic infections can be ruled out by simple laboratory procedures. Other skin conditions often should be considered, eg, psoriasis, seborrheic dermatitis, and associated fungal infections. Then there is consideration of the systemic factors, such as diabetes, infections, and others. All this should be done before the haunting glib specters of psychosomatic reactions and so-called idiopathic conditions intrude into this uncomfortable panorama of redness and discomfort.

Prevention is considered when an episode is completed or nearly completed or when complaints and discomfort are extensive and the skin appears normal, as for example, in diabetes. In the latter, an adequate prevention program may prevent secondary dermatitis, even the white, soggy dermatitis of yeast infection.

The essential basis of the prevent program is:

1. Local hygienic measures.
2. Specific recommendations related to suspected or proved etiology or etiologies.

The efficiency of removal of soil from the perianal area is increased by the use of dampened toilet paper rather than by rough dry pieces. Unfortunately, the texture of the paper also is a factor. Soft paper should be used. Wipes of many types such as Tucks® may be used. After using a wipe, the areas should be patted (not rubbed) dry. To assure adequate cleansing for the may crypts and folds in this area, a cleansing cream is used often rather than the bar of soap. A cleansing, antiseptic, medicated cream, such as Harper's Cleanser Cream,® is rubbed gently into the perianal area, rinsed gently, and patted dry.

Tight garments, such as jockey shorts on fat nonjockeys, can contribute to overheating of the perianal area and should be avoided. Nylon clothing materials are heating. If a contact factor has been suspected or found, this should be eliminated. If the perianal and adjacent areas are dry, no powder is needed. Oftentimes, sweat streams mat the powder in small or large, discrete, irritating, rough balls. Mineral oil laxatives should be avoided. Alcohol, spices, and strong seasonings should also be avoided. If antibiotics are needed, even more detailed and meticulous care should be given to this area. It appears, then, that proper hygiene for the perianal area is the most important part of the prevention program.

If the individual has diabetes, the perianal area should be protected against *Candida* infections with proper cleansing. The early treatment of any intertriginous lesions should be done with combinations of nystatin. Fungous infections elsewhere should be treated. Enterobiasis infestation in the family group can be prevented by:

1. Careful attention to cleansing the perianal area.
2. Hygiene of the family group.
3. Cleansing the nails.
4. Active, continued treatment of the individual who has the parasites. However, it is better to treat the entire family. Scotch Tape® smears, incidentally, should be taken in the morning before any washing of the area. The obese individual who has intertriginous infection in other areas, such as the folds of the axillae and inframamillary areas,

Dr. Goldman, Cincinnati, is Professor and Chairman, Department of Dermatology, and Director, Laser Laboratory, University of Cincinnati Medical Center.

Submitted November 5, 1973.

should also protect the perianal area against infection. Again, the routine is careful cleansing as indicated.

To prevent spread of other dermatoses such as psoriasis or seborrheic dermatitis into the perianal area, this region should be cleansed properly, kept as dry and free from any irritation as possible. Then the Koebner phenomenon, local irritation causing appearance and development of the generalized dermatitis-like psoriasis, seborrheic dermatitis, or lichen planus cannot develop. Dermatologic consultation is necessary here as well as for any protracted case.

The usual personality pattern for pruritus ani is the adult male, busy, harassed with irregular meals and irregular bowel movement patterns, and with regular and protracted anxieties, the tired-business-man (TBM) figure. This is the patient who relies on the symptomatic relief of topical corticosteroids—not a detailed treatment program. The hazards of such continued long-term use of topical, potent corticosteroids will be emphasized later.

The task of prevention, then, and this may not always be possible, is important and often complex. Any local discomfort in the perianal area may precipitate another uncomfortable episode and continue the disorder. Anal fixation of multiple psychodynamic mechanisms may produce inflammatory lesions through scratching and rubbing. Then, the help of an interested psychiatrist is needed, for now, it is pruritus ani in an erotic zone.

It is obvious, then, that for some patients, the prevention program must consider recommendations other than simple, proper, local hygienic measures. It has been shown that the protracted use of potent topical corticosteroids may produce a perianal atrophoderma, a clinical picture confused often with pruritus and for which these medications were given.[4] If this reddened, atrophic, local reaction is not recognized, the condition may become permanent in the corticosteroid-dependent patient. In the prevention program for minimal "idiopathic" discomfort, such creams as Unibase,® mildly phenolated Keri Cream,® or other creams, may be used. Also mild tranquilizers, even the "quietening" type of antihistamines such as Chlor-Trimeton,® may be given at bedtime.

Is all this prevention really worthwhile? To avoid a chronic and protracted uncomfortable disorder where the pruritis may be fixed centrally,[5] such a prevention program is needed even during brief periods of improvement or of clearing.

Conclusions

The prevention of pruritis ani should be considered for any type of so-called primary or more common secondary type even though such episodes may be infrequent. There is a definite prevention program which provides for detailed adequate cleansing of the perianal area, application of bland topical agents where needed, and treatment of the primary cause. The hazard of severe reactions from prolonged use of the potent topical corticosteroids is emphasized.

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Testosterone Levels—

Twenty heterosexual men 18 to 28 years of age who used marihuana at least four days a week for a minimum of six months without use of other drugs during that interval were studied. Mean (±S.E.M.) plasma testosterone—416 ± 34 ng per 100 ml—was significantly lower in this group than that in the control-group mean—742 ± 29 ng per 100 ml—for age-matched men who had never used marihuana. Decreased testosterone was dose related. Abstention from marihuana use and stimulation with human chorionic gonadotropin during continued marihuana use produced marked increases in testosterone. Measurements of liver function, circulating gonadotropins, prolactin, cortisol and thyroxine were within normal limits. Six of 17 men (35 percent) showed oligospermia, and two men were impotent. The data suggest that chronic intensive use of marihuana may produce alterations in male reproductive physiology through central (hypothalamic or pituitary) action.—Robert C. Kolodny, M.D.; William H. Masters, M.D.; Robert M. Kolodner, A.B.; and Gelson Toro, Ph.D., St. Louis: *The New England Journal of Medicine,* 290:872-874, 1974.

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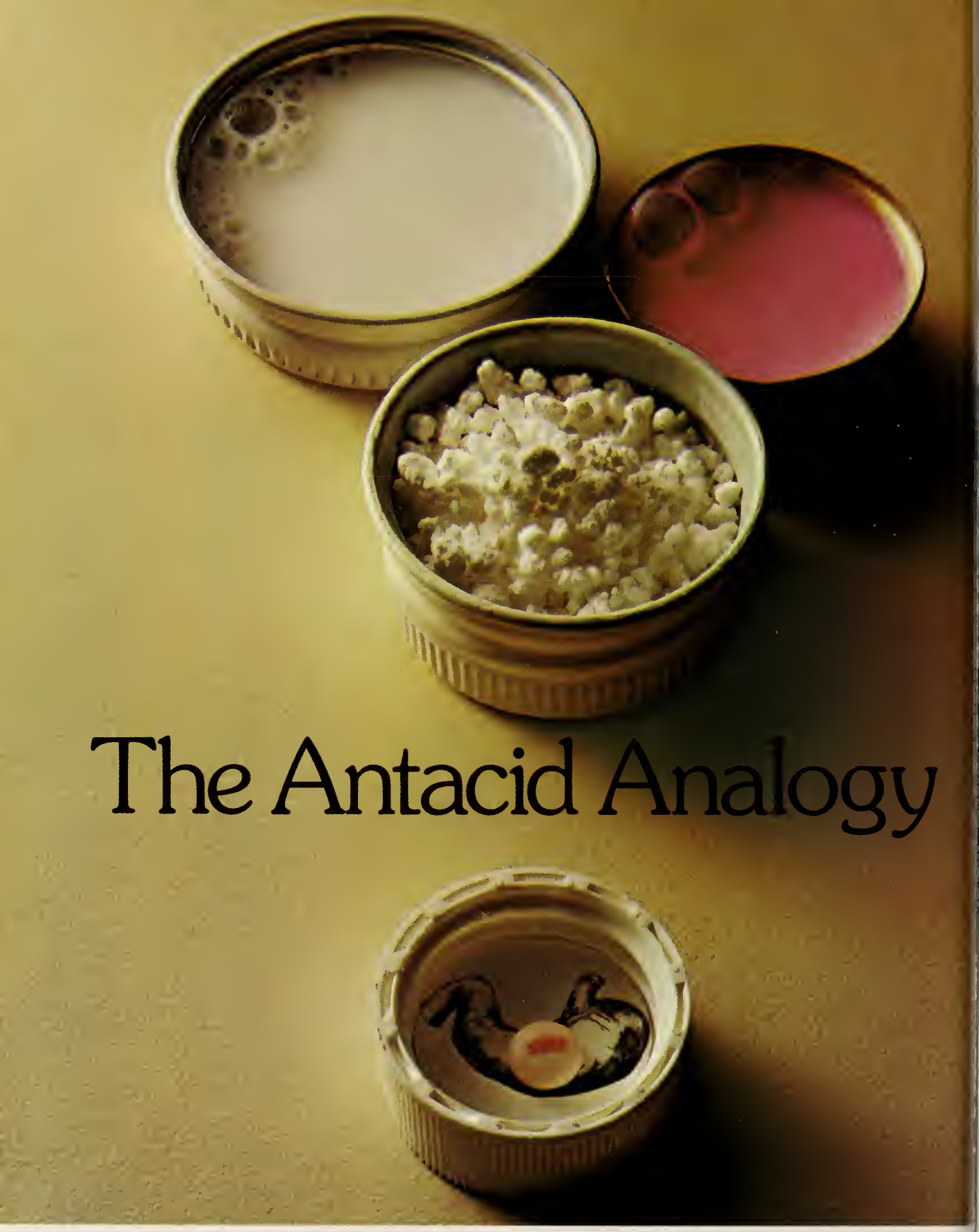
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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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cur as well as mydriasis and blurred vision. In addition the following verse reactions have been reported: nervousness, drowsiness, dizziness, somnia, headache, loss of the sense of taste, nausea, vomiting, constipan, impotence and allergic dermatitis.

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Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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Professional Activities



REPORTS

on the

1974 Annual Meeting

Ohio State Medical Association

Cleveland – May 12-15

Members of the Council Elected at the 1974 Annual Meeting

THE HOUSE OF DELEGATES at the 1974 Annual Meeting of the Ohio State Medical Association installed into office the Incoming President, named a President-Elect and one new Councilor, and reelected six Councilors. Following are brief biographical sketches of the President-Elect, Incoming President, new Councilor of the Sixth District, with additional information about other members of The Council.

Dr. Maurice F. Lieber, of Canton, was named President-Elect of the Association and will be installed as President at the 1975 Annual Meeting in Columbus. He is a Fellow of the American College of Surgeons and has been in solo practice in his native city of Canton since 1947. Part of his practice is in the field of industrial surgery from his association with the Republic Steel Corporation and the Diebold Corporation.



Maurice F. Lieber, M.D.

Long interested in medical organization work, he is a Past President of the Stark County Medical Society, a long-time member of its Council, and has served the local Society in many other capacities. In addition, he has served as President of the Aultman Hospital Medical Staff and as Chief of Surgery at Aultman. He is also on the Courtesy Staff of Timken Hospital of Canton and the Molly Stark Hospital, also of Canton.

Dr. Lieber was first elected to The Council of OSMA in 1969 as Councilor of the Sixth District and has served five years in that office. During that time he has served on numerous committees on the state level—as chairman of the Committee on Nursing, the Committee on Private Practice, and the Auditing and Appropriations Committee, and as a member of the Legislative Committee, OSMA Building Committee, Medical Indemnity Liaison Committee, and several ad hoc committees.

Dr. Lieber was born in Canton and attended public schools there. He received his A.B. degree from Washington and Jefferson College in 1934 and his M.D. degree from Johns Hopkins University School of Medicine in 1938. He continued at Johns Hopkins and Union Memorial Hospital, in Baltimore, for surgical training.

In 1941 he entered military service in the Army and became chief of surgery at the 10th Station Hospital, attaining the rank of Colonel. Following completion of his active tour of duty, he returned to surgical training.

He is a member of the United Presbyterian Church and several Masonic bodies including the Scottish Rite and Shrine. He is associated with the Health Foundation Board of the Canton United Fund, the Chamber of Commerce, Stark County Historical Society, Canton Library, the Players' Guild and the YMCA. He also belongs to the Canton Club and has served as team physician for the Canton McKinley High School football squad.

In addition to his local and state associations, he is a member of the American Medical Association, a member of the Ohio Chapter, American College of Surgeons, the Johns Hopkins Surgical Association and the Cleveland Surgical Society. He also is a member of the OSMA Speakers' Bureau and the AMA Speakers' Bureau.

Dr. Lieber is married to the former Doreen Godfrey, formerly a resident of Liverpool, England, and the couple has two daughters, Mrs. Diane Lieber Spera, of Denver, Colorado, and Jennifer Anne Lieber, a senior student at Mount Union College.

An avid golfer, Dr. Lieber is a member of the Congress Lake Club and the Ohio Medical Golfers Association.

Incoming President

Dr. James L. Henry, of Grove City, was installed as President of the Ohio State Medical Association at the final session of the House of Delegates and assumed office at that time. He was named President-Elect at the 1973 Annual Meeting in Columbus after serving on The Council for six years as Treasurer and Secretary-Treasurer of the Association.

Dr. Henry is a family practitioner in Grove City, is on the staff of Mt. Carmel Hospital, Columbus, and has served for more than 12 years as chairman of the Mt. Carmel Department of General Practice.



James L. Henry, M.D.

His activities in medical organization work have been numerous. As a member of the Academy of Medicine of Columbus and Franklin County, he has served that organization as Secretary-Treasurer (1954-1958), as President-Elect (1958) and as President (1959). He has also served on a number of committees of the Academy. He was chairman of the Utilization and Review Committee, the Medical Services Committee, and the Family Practice Committee, and was a member of the Professional Relations Committee and the Academy representative to the Press Code Committee.

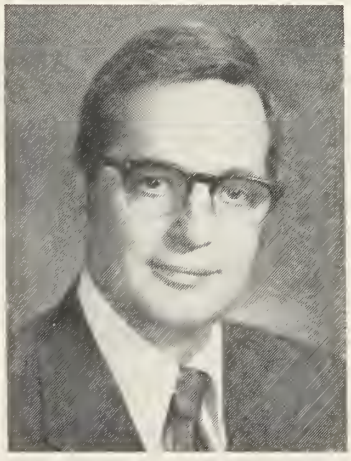
After careful planning and analysis, The Council in 1971 established the Medical Advances Institute (MAI), and Dr. Henry was elected its first President, and helped steer it through its organization period. He has since resigned the presidency but remains a member of the Board of Directors. MAI was formed to develop a statewide systematic approach for assessing the quality and appropriateness of cost of hospital-based medical care. Dr. Henry has traveled extensively, speaking in behalf of MAI and has appeared before hearings in Washington on behalf of the principles involved. He also has written a number of articles for publication on peer review and utilization review.

The Incoming President is a native of Spokane, Washington, but lived much of his early life in Grove City where he graduated from high school. He received his Bachelor of Arts degree from Ohio State University and his medical degree from the OSU College of Medicine in 1944. After an internship at the former St. Francis Hospital, Columbus, he entered military service, and attained the rank of Captain before his release from active duty in 1947. Among assignments during the war, he was chief of the Outpatient Service at Camp Kilmer, New Jersey.

Since becoming a member of The Council, Dr. Henry has served as a member or chairman of several committees, including the Building Committee, Employees' Pension Committee, Woman's Auxiliary Advisory Committee, Peer Review Committee and the Auditing and Appropriations Committee.

He is a member of the American Medical Association, the American Academy of Family Physicians and the Ohio Academy of Family Physicians.

Dr. Henry is married to the former Virginia Hysell, and the couple has two children, a son James, and a daughter Diane.



C. Edward Pichette, M.D.

Sixth District Councilor

The House of Delegates elected Dr. C. Edward Pichette, of Youngstown, to fill the remaining year of the unexpired term of Dr. Lieber as Councilor of the Sixth District.

Dr. Pichette is a Fellow of the American College of Surgeons and a practicing urologist in Youngstown. He was president of the Staff of Saint Elizabeth Hospital from 1960 to 1965, having served in many staff positions prior to being ele-

vated to the presidency. He is still on the Hospital's Executive Committee.

He was President of the Mahoning County Medical Society during 1973, having also served for many years as a member of the Society's Council. Before being named to the OSMA Council, he had served for four years in the OSMA House of Delegates as a Delegate from Mahoning County.

Dr. Pichette is a native of Syracuse, New York, and attended public schools there. He received his A.B. degree from Syracuse University in 1934 and his M.D. degree from the State University of New York Upstate Medical Center at Syracuse in 1938.

He interned at Syracuse Medical Center, took one year of pathology at Rhode Island General Hospital, Providence, then took two years of general surgery in Youngstown, serving as chief resident the last year.

From 1943 to 1946 he was in service, spending his period of service partly in the Yukon and Alaska and the rest in Central America.

After his return to this country, he served a year in a refresher course at Saint Elizabeth Hospital. From 1947 to 1949 he was in residency in urology at St. Vincent's Hospital, Toledo.

He returned to Youngstown in 1949 where he has remained in the practice of urology since. In addition to being a Fellow of the American College of Surgeons and affiliated with its Ohio Chapter, he is a member of the Mahoning County Medical Society, Ohio State Medical Association, and the American Medical Association.

In 1940 he was married to Eleanor M. Jones, formerly of Ilion, New York. Dr. and Mrs. Pichette have three sons: David E. Pichette, M.D , presently in urological residency at Ohio State University Medical Center; Richard Edward Pichette, now taking his Masters in Finance at the University of Cincinnati; and James Michael Pichette, presently a junior in pre-law at the University of Cincinnati.

Dr. Pichette is a member of St. Charles Church, in Boardman, and formerly served as president of the Catholic Physicians Guild of Youngstown.

His extra curricular activities are limited to family and friends, reading and listening to music, and lately some efforts on the golf course.

Other Members of The Council

Dr. Oscar W. Clarke, Gallipolis, continues on The Council for another year as the Immediate Past President.

Dr. William M. Wells, Newark, is serving his first three-year term as Secretary-Treasurer.

Dr. Stephen P. Hogg, Cincinnati, was reelected Councilor of the First District. He was first elected to that office in 1972.

Dr. John C. Smithson, Findlay, was reelected Councilor of the Third District. He was first elected to that office in 1972.

Dr. John J. Gaughan, Cleveland, was elected to his first full term as Councilor of the Fifth District. He was appointed by The Council in July 1973 to fill the remainder of the unexpired term of the late Dr. David Fishman.

Dr. Robert E. Rinderknecht, Dover, was reelected Councilor of the Seventh District. He was first elected to that office in 1972.

Dr. Thomas W. Morgan, Gallipolis, was reelected Councilor of the Ninth District. He was first elected to that office in 1972.

Dr. Robert G. Thomas, Elyria, was reelected Councilor of the Eleventh District. He was first elected to that office in 1971 to fill one year of the unexpired term of Dr. Schultz, and was reelected for his first full term in 1972.

Councilors in the midst of two-year terms are Dr. James G. Tye, Dayton, Second District; Dr. George N. Bates, Toledo, Fourth District; Dr. Richard E. Hartle, Lancaster, Eighth District; and Dr. James C. McLarnan, Mt. Vernon, Tenth District.

President's Address

Presented May 12, 1974 Before the House of Delegates of the Ohio State Medical Association, in Cleveland

By Oscar W. Clarke, M.D.
Gallipolis, Ohio

THIS EVENING I would like to indulge in the luxury of viewing our past accomplishments presenting a scholarly paper based on the wisdom of the past, dealing with the high ideals of our profession, our present accomplishments and our dreams and desires for the future. However, the pressure of the times does not afford me such luxury. I must, instead, address you regarding the most urgent problems facing the medical profession in Ohio.

Before I do so, I would like to pay my personal tribute to the Executive Staff of the Ohio State Medical Association; Hart Page, Chuck Edgar, Jerry Campbell, Robert Clinger, Mrs. Gail Dodson, Mrs. Katherine Wisse, David Rader and Douglas Houser. Also, Mr. Gordon Moore for his many years of dedication to *The Journal,* and to Dr. Perry Ayres for his editorship of *The Journal*—and particularly the Headquarters' secretaries and clerical staff for their efficient help. Without the loyalty and devotion of this group, nothing would have been accomplished this past year.

I would like to also take this opportunity to thank my partners and fellow staff members at the Holzer Medical Center for their support and for covering my practice obligations during my many but necessary absences.

It is quite often a human failing to take some of the most essential things in ones life for granted. I shall not make that error tonight. I would like to express to my wife, Susan, my appreciation for her understanding, loyalty and real love during the demanding schedule of this past year.

Now, let us examine together some of the problems, the opportunities and the options facing us by the presentation of another revolutionary milestone in the practice of medicine in this country. That milestone is Public Law 92-603, specifically, the section dealing with Professional Standards Review Organizations, or known in some circles as the "Bennett Amendment."

In Ohio we had the foresight to anticipate this political development two and a half years ago. The amendment was brought out under the guise of assuring quality care to those patients who receive government subsidization for their medical care. However, it is interesting to note that, in the entire Bennett Amendment, there are approximately **123 references to cost containment and there are only four references to quality care.**

In spite of all the subterfuge, the basic factor in this problem is that politicians have used medicine as an emotional issue—they found they could generate emotional support if they conjured "deficiencies" of medicine hard enough and promised the people of this country another great bonanza of "something for nothing." Let no one be deceived. The so-called crisis in medicine in this country was generated by politicians for political purposes, and they have created a monster they cannot control. They have caused medical care costs to skyrocket by their simple ignorance of the economic facts of life. It is an economic fact that, when one creates an unprecedented demand—not need but demand—financed by the entire public treasury without adequate preparation to provide the suppliers for this demand, then they create their political crisis. Compounding this is the unprecedented inflation that this country is experiencing—under so-called price controls—and the tremendous advances in sophistication and expense of the hardware of medical practice and the cost becomes unbelievable.

When the full realization of what had happened dawned upon the politicians, it was a fact of politics that someone else had to be proclaimed the scapegoat and they chose the health professionals and the medical care team of America.

The philosophy of the Ohio State Medical Association has been that we have developed and shall continue to develop methods of reasonable peer review, not professional standards organizations as controlled by the federal government. Our peer review shall be done for the patients, by their doctors, on behalf of all patients and not for the benefit of a frightened politician trying to explain why the cost of medical care has increased.

On December the 5th, 1973, at the Clinical Convention of the American Medical Association in Anaheim, California, I read before the House of Delegates Reference Committee "A" and subsequently read on the floor of the House of Delegates the following statement:

1. The Ohio State Medical Association does not support the PSRO section of Public Law 92-603.

2. The Ohio State Medical Association hopes this section of the law might be repealed.

3. In the event this law is or is not repealed, the Ohio State Medical Association has developed a computerized Peer Review System —controlled and operated by licensed, practicing physicians—to assure quality of care of all

Ohio patients, producing data that will demonstrate the excellence of this care.

4. In the event the Secretary of the Department of Health, Education and Welfare does not accept Ohio's Peer Review System, then we shall pursue all avenues of recourse available to us.

However, in the event the secretary accepts Ohio's Peer Review Systems then the following resolution of the 1973 House of Delegates of the Ohio State Medical Association shall apply:

"RESOLVED, That if any rules or regulations put forth by the Secretary of Health, Education and Welfare constitute a violation of medical ethics or Ohio State Medical Association policy and—or causing deterioration of the quality of care rendered to patients, then the Ohio State Medical Association Council shall immediately recommend to the Medical Advances Institute that it notify the Secretary of Health, Education and Welfare that any provisional agreement be terminated."

To further clarify this resolve, I would like to present tonight the action taken by this OSMA House in 1973. It was Substitute Resolution 29-73, MAI-PSRO, which fixes the official policy of the Association. That resolution states:

WHEREAS, In May 1972, the Ohio State House of Delegates endorsed the concept in development of a program of Professional Standards Review and,

WHEREAS, The 1972 OSMA House of Delegates recommended to Medical Advances Institute that it investigate and develop methods and mechanism for a Professional Standards Review Organization for the State of Ohio, and

WHEREAS, The federal Congress has passed Public Law 92-603 requiring the implementation of PSRO by 1974, and,

WHEREAS, Practicing physicians from throughout the State of Ohio have developed Quality Assurance Criteria for disease entities and

WHEREAS, Medical Advances Institute has established an organization that meets the requirements of the present federal laws for Professional States Review in the State of Ohio, and has developed Quality Assurance Criteria that are computer acceptable, therefore be it

RESOLVED, That the Ohio State Medical Association House of Delegates recommend to the Medical Advances Institute that it accept financial aid to develop continuing programs of PSRO, and be it further

RESOLVED, That Medical Advances Institute be encouraged to seek a provisional contract agreement with the Secretary of Health, Education and Welfare to act as the PSRO for the area of the State of Ohio in accordance with Public Law 92-603, and be it further

RESOLVED, That if any rules or regulations put forth by the Secretary of Health, Education and Welfare constitute a violation of medical ethics or OSMA policy and—or cause the deterioration of the quality of care rendered to the patients, then OSMA Council shall immediately recommend to MAI that it notify the Secretary of Health, Education and Welfare that any provisional agreement be terminated.

I am fully confident that the policy of this organization is fairly and clearly stated. There has been heard throughout the land the battle cry—"Repeal PSRO." I have, as of 24 hours ago, contacted all of the reliable sources of information available both to the Ohio State Medical Association and to the American Medical Association. As of this date, I have reliable assurances that "repeal" will not take place. However, I can assure you that the alternative approach now being forcibly advocated and being pushed to its maximum extent is the approach of amending the present PSRO Law. On May the 8th, the AMA presented before Senator Herman Talmadge's Senate Health Committee testimony on 19 proposed amendments to the PSRO Section of Public Law 92-603. The 19 amendments were incorporated in a single legislative proposal. Those of you who are familiar with these amendments will be able to understand that the PSRO Section of Public Law 92-603 will certainly not be the same if those amendments are adopted by Congress.

Contrary to the deliberations and advice of those most intimately associated with this problem of amendment are those who close their minds to the amendment process and argue that they will proceed with a "repeal" campaign. I, for one, wish them the best of luck. However, knowing the working of the legislative process, the amendment route will be the one most likely to produce results.

At this point I would like to do my very, very best to urge that each delegate here carefully consider one of the major problems that is presented to us, that problem is either the **deliberate** or **uninformed action** by some to equate the Ohio State Medical Association Peer Review System-MAI with the federal government's Professional Standards Review Organization Section of Public Law 92-603. **This simply is not true!**

The Ohio State Medical Association's Peer Review System offers to the practicing physician of this state one of the few workable, feasible and acceptable mechanisms both to provide evidence of our quality of care and to act as a positive

shield from further intrusion by the federal government between the doctor and his patient.

There is little doubt that the "tug-of-war" which the PSRO debate has engendered merely reflects the larger, more deeply rooted question of federal controls. The medical profession's adamant opposition to imposing federal regulations is responsible for the concern over the rigidity of PSRO. But, if one can live with the assumption that some degree of federal control is inevitable, the question then becomes "what type of control is necessary—rigid or flexible?" What makes the government's Professional Standards Review Organization scheme dangerous is that, as originally conceived it was actually the perversion of a healthy idea, that of Peer Review, and Peer Review should be supported as such. My position has been consistently that, if done right, Peer Review can be a useful tool in measuring the quality of medical care. It is at this junction that the onus has shifted, that the responsibility for creative and constructive implementation falls clearly on the shoulders of the physician. If not shouldered, the whole profession stands to lose its independence.

The Ohio State Medical Association's Peer Review mechanism is a program primarily directed to assuring that timely, effective, quality medical care is given to all patients in Ohio.

The program known as Medical Advances Institute furnishes data and screens cases to be considered by local staff physicians employing a uniform, scientific method of evaluating the care rendered to individual patients.

MAI Peer Review Systems has worked very hard to build upon the present operating Peer Review Systems. MAI closely involves medical societies and specialty groups as well as the hospital staffs served by members of medical societies.

MAI Peer Review Systems has been wrongly criticized for its attempts to maintain a solidarity and uniformity of concept. This has been done for the purpose of preventing fragmentation and separation of the several sectors of physicians in Ohio.

MAI-Peer Review Systems has created a sophisticated technique for reviewing the in-patient care of all patients in Ohio. The system mechanically collects cases which are in variance with the criteria established by licensed, practicing physicians throughout the state and modified and adopted to the local need.

Only when the exception requires critical evaluation is a physician required to make a judgment. And, importantly, only a physician makes the clinical determinations. MAI Peer Review System is not a claims processing operation for any third party, federal government included.

In the early development of MAI Peer Review Systems, 12 councilors representing the 12 districts of Medical Advances Institute were selected by local medical organizations. This assured that physicians developing the policies and procedures of MAI would truly represent local practicing physicians.

MAI Peer Review Systems has modified this procedure so that local representation to the PSRO Council will be reelected every three years.

This policy body makes final professional determination as to the effectiveness, efficiency and performance of regional organizations.

The Governor's Task Force on Health Care and PSRO bureaucrats and PSRO do not believe, apparently, that physicians can honestly evaluate the quality, quantity and cost of medical care deliverance.

Public Law 92-603 requires a specific mode of appointment which does not give appropriate regard for licensed practicing physicians.

The MAI Peer Review Systems demonstrates that concerned, involved physicians can indeed create an effective, efficient, peer review program without government largesse or government input. In the consideration of this problem our physicians do not need keepers, the physicians need only the opportunity to perform.

Before anyone should be mistaken concerning the future, if the present PSRO legislation should be repealed or amended, let me hasten to bring you back to the facts of life.

The Secretary of Health, Education and Welfare has repeatedly stated that the concept of PSRO would be carried out under other provisions of the Medicare-Medicaid Law and by regulatory authority even if PSRO were repealed. Health, Education and Welfare cites—rightly or wrongly—several sources of authority, namely:

Medicare-Medicaid Law

Section 1815 (I) "The Secretary shall periodically determine the amount which should be paid . . . to each provider of services . . . except that no payment shall be made to any provider unless he has furnished such information as the Secretary may request . . .

Section 1861 (K) "A Utilization Review Plan of a hospital or skilled nursing facility shall be considered sufficient if it . . . provides . . . review on a sample or other basis of admission . . . and the professional services . . . furnished, (A) with respect to the medical necessity of the service and (B) for the purpose of promoting the most efficient use of available health facilities and services.

Section 1902-A (33) Provides "(A) That the State Health Agency, or other appropriate State Medical Agencies shall be responsible for establishing a plan, consistent with regulations

prescribed by the Secretary, for the review by appropriate professional health personnel of their appropriateness and quality of care and services.

I have said before and I am repeating it tonight: The Ohio State Medical Association has the mechanism for adequate Peer Review and, if accepted and implemented, this Peer Review System shall be the only review system in Ohio. Should the federal government attempt to interfere or distort this system, then I feel that any entanglement with the federal government should be dissolved and that the Peer Review System should continue to proceed as outlined and directed. If the federal government withholds payment or attempts to obstruct this process in any way, then it is the full intention of this Association to secure an injunction from a federal court and have a federal judge tell us, not a bureaucrat in Columbus or in Washington, in what manner we err.

Medical Advances Institute is not an instrument belonging to the United States Department of Health, Education and Welfare, nor to the Ohio Department of Health. MAI was established and designed by OSMA to provide professional medical review for all hospital patients, not just those in the Medicaid and Medicare categories. MAI, if supported by the Medical practitioners of Ohio, can provide proof to all third parties, not just HEW—that physician-directed medical and other services and health facilities in Ohio are efficient, are of high quality and are reasonable in cost.

In other words, MAI can be Ohio Medicine's most effective mechanism to prove that our system of medical care is the best bargain in America today.

I would like to call to the attention of the delegation here tonight the fact that the Director of the Ohio Department of Public Health recently held a hearing on Monday, April 29th in regard to Section 1122 of the Medicare Act which is wrongly referred to as "Certificate of Need." It is actually found under the heading of "Limitation on Federal Participation for Capital Expenditures." This Section has been misrepresented and it is being expanded beyond its true legality. It is being interpreted by the Director to attempt to gain power to act as an arbiter of what is necessary in this state and what is not in regard to health facilities and services. It removes effective local and regional planning from the picture. It also has built into it terminology which could be construed by the State Health Director to empower him to invade the professional services being rendered in hospitals.

In Wisconsin, the State Health Director contends he is empowered to classify a doctor's office as a "health facility." If true, he could invade your private office and tell you which of your services he deems necessary and which are unnecessary.

You can rest assured that your Ohio State Medical Association was on the scene at the April 29 hearing. We clearly outlined our position in regard to this so-called "Certificate of Need" bureaucratic self-determination. We have opposed every feature of it that we feel illegal and unwarranted.

Another important hearing was held May 3rd by Kenneth E. DeShetler, Superintendent of the Ohio Department of Insurance, in regard to proposed rule IN-1738-01. The Ohio State Medical Association appeared at this hearing and stated the Ohio State Medical Association's positions on the so-called Health Maintenance Organizations. We also presented the highlights of our comments on the rules being proposed. We further suggested deletions and amendments to these rules and we noted that the record will be kept open for further input as required, for 20 days after the May 3rd hearing.

All members of the Ohio State Medical Association will receive further information and details concerning our positions on both of these efforts against federal and state intrusion into the private practice of medicine.

The evening is drawing late and since the American people like their horror movies and horror stories late at night at the end of the TV programming, I will finish this part of my presentation with the horror story of 1973. Presented in the closing of 1973, it is the so-called Governor's Health Care Task Force report. I used the term "so-called" for the Governor himself states that it is not his report, it is "a report of the people." This document directed itself among other matters to the following major problems and I will give this to you briefly:

1. Undergraduate and Medical Education.
2. Emergency Medical Services
3. Medical Practice Alternatives and the Hospital Practice of Medicine
4. Health Department Reorganization
5. Certification of Need
6. Professional Board Reorganization—Lay members
7. Medical Malpractice and Patient Grievances; Discovery Rule in Malpractice; Term of Statute of Limitations; Application of the Re Ipsa Loquita Doctrine; Doctrine of Informed Consent—Medical Records
8. Quality Assurance
9. Cost Containment
10. Blue Cross and Blue Shield
11. Repeal of Antisubstitution Drug Laws.

And it was most vocal in what it **did not** have to say and in a study of the report I could

not find one mention made about The Chiropractic Cult in the State of Ohio.

I feel the best comment made on this book of horrors could best be summarized by the summary of Dr. William Schultz, Immediate Past President of the Ohio State Medical Association and a member of the Governor's Task Force on Health Care. To quote Dr. Schultz: "It appears that the staff writers of the Governor's Task Force report equate long lines, huge waiting rooms and impersonal care with quality medicine. Many ideas which would result in better quality and better access are touched upon briefly or not at all. Such items as production of more primary care physicians control of chiropractors and others who prey upon misunderstanding on the part of the public; protection of physician-patient relationship from outside interference, and the provision for adequate and acceptable Peer Review, Utilization and "Fear Review."

Costs of health care have risen drastically in the last few decades but so has quality—and so have taxes—and so have all living costs. Expensive but vital health care equipment and personnel are available now that did not exist ten years ago. Increasing demand for services caused by government has also increased total expenditures. The public must someday make its decision concerning health care costs. Do Americans want the best possible medical care or do they want a rigid cost-accounting system to produce the "cheapest" medical care with no regard to quality. In addition, the people must learn that adequate health maintenance is not something that the health care system or big government can provide. It is an individual thing. As long as Americans continue to smoke, drink and overeat—as long as they refuse to adequately care for themselves by proper exercise, diet, education and employment—no HMO "magic" can maintain their health.

True health maintenance is personal, not institutional and no amount of mass government spending is going to make up for that personal responsibility.

In short, gross reorganization without allowing for interpersonal relationship will not result in increased quality or access of medical care. The Task Force report, if implemented, will result in state control of the personal medical care in Ohio.

The state would decide who would practice what types of medicine and where. The state would control access to health care by controlling the location and number of health-related technicians and their equipment. The state would select practitioners for the public by supporting pre-paid practices. The state would control reimbursement for almost all health care providers by taking over Blue Cross, by doing away with Blue Shield and continuing to operate such programs as Medicare and Medicaid.

In reality, the government would then be in the business of providing health care to Ohioans. Past experiences indicates that, when government takes such controls, costs go up, and quality goes down.

If American health care is so terrible, why are Americans healthier, taller, and living longer?

Washington news reports May 6 said the federal government was bewildered to learn that death rates in nine different major disease categories had been reduced—gone down, not up—in America during the last 20 years.

And *The New York Times* went on to say:

"But no one seems to know why."

I can tell them why. Medicine has been telling Washington why for the past 30 years. The answer is pure and simple: Americans have enjoyed and continue to enjoy the best medical care in the world.

That's the reason. The federal bureaucrats and politicians just won't admit it.

The same news reports said the U.S. Division of Vital Statistics reported a significant **increase** in deaths from cirrhosis, cancer, bronchitis, emphysema and asthma. I can tell Washington why. As long as Americans are forced to breathe fouler and fouler air, and use contaminated water our grandfathers would not have given their horses, the death rates in those categories will continue to increase.

We in medicine must continue to emphasize and reemphasize three vital points.

Point No. 1: Regardless of what anyone says, Americans enjoy the best medical care today of any nation in the world.

Point No. 2: Americans have the greatest personal **access** to medical care of any nation in the world. The problem is that they don't take advantage of that access. Just because Americans will not enter health care's door doesn't mean the so-called delivery system is wrong. There is nothing wrong with the system—or systems. **The wrongness is the failure of Americans to use it.**

Point No. 3: As OSMA told the public last December in regard to Governor Gilligan's so-called Health Care Task Force report, "The free and independent people of the State of Ohio will not tolerate a medical and health Czar and the resultant effect on their personal lives."

I don't believe the American people will tolerate such a czar at the federal level. We in medicine must develop a health care "truth serum."

Members of the House of Delegates, **what do you believe?** I personally call on each of you to think, to talk, to act and to vote on the serious deliberations you undertake this week. I ask that you do this according to your beliefs. If you do this, I am confident of the results.

Index to Actions on Resolutions

Report of Resolutions Committee No. 1 begins on page 446
Resolutions Committee No. 2, page 451
Resolutions Committee No. 3, page 455

Resolution No....	Subject and Sponsor	Referred to Resolutions Committee No....
1	**New Councilor District** (Trumbull County Medical Society)	No. 1
2	**New Councilor District** (Ashtabula County Medical Society)	No. 1
3	**Circumvention of Democratic Process** (Ross County Medical Society)	No. 1
4	**Appointment of Members to Resolutions Committees** (Mahoning County Medical Society)	No. 1
5	**Dues Increase** (Council of the OSMA)	No. 1
6	**Public Relations Levy** (Council of the Lake County Medical Society)	No. 1
7	**New Councilor District** (Lake County Medical Society)	No. 1
8	**Constitution and Bylaws of OSMA** (Huron County Medical Society)	No. 1
9	**Information and Education Serve Freedom** (Huron County Medical Society)	No. 1
10	**Professionalism** (Alford C. Diller, M.D., Delegate Van Wert Medical Society)	No. 1
11	**To Commend the Ohio Foundation for Medical Care** John N. Meagher, M.D., Delegate Academy of Medicine of Columbus)	No. 1
12	**Affiliate Membership** (John J. Gaughan, M.D., Fifth District Councilor and the Academy of Medicine of Cleveland)	No. 1
13	**Professionalism** (Academy of Medicine of Lima and Allen County)	No. 1
14	**Governor's Task Force on Health Care** (Summit County Medical Society)	No. 1
15	**Budget Publication** (Academy of Medicine of Cincinnati)	No. 1
16	**Compulsory Post Graduate Medical Educational Program** (Academy of Medicine of Cincinnati)	No. 1
17	**To Reject P.S.R.O.** (Delaware County Medical Society)	No. 2
18	**Professional Standards Review** (Erie County Medical Society)	No. 2
19	**Preadmission Certification** (Erie County Medical Society)	No. 2
20	**Standardized Insurance Form** (Lorain County Medical Society)	No. 2
21	**Rejection of PSRO and MAI** (Mahoning County Medical Society)	No. 2
22	**AMA Efforts to Repeal PSRO** (Mahoning County Medical Society)	No. 2
23	**Noncompliance with PSRO** (Ross County Medical Society)	No. 2
24	**Abolish MAI** (Ross County Medical Society)	No. 2
25	**Support AAPS Court Test of PSRO** (Ross County Medical Society)	No. 2
26	**Public Opinion and PSRO** (Council of the Lake County Medical Society)	No. 2
27	**MAI and PSRO** (Council of the Lake County Medical Society)	No. 2
28	**OSMA Support for Repeal of PSRO Law** (Mahoning County Medical Society)	No. 2
29	**PSRO** (Stark County Medical Society)	No. 2
30	**PSRO and the Ohio Legislature** (Huron County Medical Society)	No. 2
31	**OSMA and Medical Advances Institute** (Huron County Medical Society)	No. 2
32	**PSRO Unconstitutional—OSMA to Sue HEW** (Huron County Medical Society)	No. 2
33	**H.R. 9375 and 11394—To Repeal PSRO** (Huron County Medical Society)	No. 2
34	**MAI Peer Review System** (Academy of Medicine of Lima and Allen County)	No. 2

Note: This index is for reference purposes only, and is not a part of the Official Proceedings of the House of Delegates.

Resolution No. . . .	Subject and Sponsor	Referred to Resolutions Committee No. . . .
35	**Repeal of P.L. 92-603** (Wayne County Medical Society)	No. 2
36	**Repeal of Prenatal Gonorrhea Testing** (Stark County Medical Society)	No. 3
37	**Comprehensive Health Education in Ohio's Public Schools** (John J. Gaughan, M.D., Fifth District Councilor and the Academy of Medicine of Cleveland)	No. 3
38	**Welfare Department Payments** (Council of the Lake County Medical Society)	No. 3
39	**National Health Insurance** (Council of the Lake County Medical Society)	No. 3
40	**Common Cause** (Council of the Lake County Medical Society)	No. 3
41	**Day of Protest** (Council of the Lake County Medical Society)	No. 3
42	**Let Money Follow People** (Council of the Lake County Medical Society)	No. 3
43	**Sports Medicine Commendation** (Jefferson County Medical Society)	No. 3
44	**Assignment Via "Healthcard"** (C. G. Madsen, Jr., M.D., Delegate, Lake County Medical Society)	No. 3
45	**Out-Patient Diagnostic Procedures** (Huron County Medical Society)	No. 3
46	**Liability Would Shift to the Provider** (Huron County Medical Society)	No. 3
47	**Medical Coupons** (Huron County Medical Society)	No. 3
48	**Repeal of the Changes in the Ohio Prenatal Testing Law** (John H. Sanders, M.D., Delegate, Academy of Medicine of Cleveland)	No. 3
49	**Constitutional Amendment on Abortion** (John H. Sanders, M.D., Delegate, Academy of Medicine of Cleveland)	No. 3
50	**Bureau of Crippled Children's Services** (Academy of Medicine of Columbus and Franklin County)	No. 3
	Report of the Committee on Judicial and Professional Relations on Ethics of Charging Interest Rates (3-73) Ethical Status of Provider Agreement (30-73)	No. 3

3,500 Reasons Why

At each session of Congress and our State Legislature, approximately 3,500 medically-related bills are introduced. Many have only an indirect effect on health care while others would directly revise or reorganize the manner in which you practice medicine and care for your patients.

The Ohio Medical Political Action Committee uses your contribution dollars to support state and federal candidates who will listen objectively to medicine's legislative position and give serious consideration to medicine's well-reasoned views. The more support OMPAC receives from you and your colleagues the stronger your voice will be.

Join us in 1974 — we can go a long way — TOGETHER.

If you have not already joined, send your $25 check to:

OMPAC
Box 5617
Columbus, Ohio 43221

Proceedings of the House of Delegates 1974 Annual Meeting

MINUTES OF FIRST SESSION

THE FIRST SESSION of the House of Delegates of the Ohio State Medical Association was convened at 7:00 p.m., Sunday, May 12, 1974, at the Sheraton Cleveland Hotel, Cleveland, with President Oscar W. Clarke, Presiding.

The House received a presentation from the American Medical Association, entitled "Federation Eavesdrop."

The Invocation was offered by Rev. Duane Smith, Associate Minister, Grove City Methodist Church, Grove City.

Dr. Theodore J. Castele, President of the Academy of Medicine of Cleveland and Cuyahoga County, welcomed the delegates and guests to Cleveland.

Dr. Max H. Parrott, Portland, Oregon, American Medical Association Trustee, brought greetings from the AMA and discussed ongoing AMA programs.

Report on Delegates Present

Dr. Joseph A. Bonta, Columbus, Chairman of the Credentials Committee, reported that out of 170 delegates eligible to vote, 158 were seated. A number of alternate-delegates, guests, officers of county medical societies and executive secretaries were in attendance.

1973 Minutes Approved

The minutes of the 1973 sessions of the House of Delegates, as published in the July, 1973, issue of The Ohio State Medical Journal, were approved by official action.

Introduction of Guests

Dr. Clarke introduced the following guests:

Dr. Irving B. Tapper, Cleveland, representing the Ohio Dental Association; Miss Carol E. Randall, R.N., Lakewood, First Vice President, Ohio Nurses Association; Dr. J. Richard Costin, Columbus, President, Ohio Osteopathic Association of Physicians and Surgeons; Dr. David A. Barr, Lima, President, Ohio Academy of Family Physicians; Mrs. Karl Ulicny, Salem, President, and Mrs. S. J. Glueck, Springfield, President-Elect, Woman's Auxiliary to the Ohio State Medical Association; Kenneth J. Shoos, Chairman of the Board, Ohio Hospital Association; James E. Pohlman, Legal Counsel; James W. Rosevear, Associate Director, AMA Field Service; and Guy D. Beaumont, AMA Field Service.

OSMA Past Presidents Introduced

The following Past Presidents of the Association were introduced: Dr. Carl A. Lincke, Carrollton; Dr. H. M. Clodfelter, Columbus; Dr. Charles L. Hudson, Cleveland; Dr. Richard L. Meiling, Columbus; Dr. Frank H. Mayfield, Cincinnati; Dr. George W. Petznick, Cleveland; Dr. Robert E. Tschantz, Canton; Dr. Henry A. Crawford, Cleveland; Dr. Lawrence C. Meredith, Oberlin; Dr. Theodore L. Light, Dayton; Dr. Robert N. Smith, Toledo; Dr. Richard L. Fulton, Columbus; Dr. P. John Robechek, Cleveland; and Dr. William R. Schultz, Wooster.

Also introduced were former members of the Council: Dr. Chester H. Allen, Portsmouth; Dr. Dwight L. Becker, Lima; Dr. Paul F. Orr, Perrysburg; Dr. Sanford Press, Steubenville; and Dr. Edwin R. Westbrook, Warren.

Thanks Expressed

Dr. Clarke expressed the thanks of the Ohio State Medical Association to Dr. Jack E. Tetirick, Chairman, and to the members of the Committee on Scientific Work for their contributions in planning the 1974 meeting.

Report of Woman's Auxiliary President

Mrs. Karl Ulicny, Salem, President of the Woman's Auxiliary to the Ohio State Medical Association, was escorted to the podium by Dr. Maurice F. Lieber, Canton, Sixth District Councilor, and a member of the Woman's Auxiliary Advisory Committee. Mrs. Ulicny reported on Auxiliary activities during her administration, with special emphasis on the legislative, AMA-ERF contributions and health education programs. (See Page 466).

AMA-ERF Checks Presented

In the absence of Dr. Philip Hardymon, Columbus, Chairman of Ohio's Committee for the American Medical Association's Education and

Research Foundation, Dr. Clarke made the presentation of the AMA-ERF checks, as follows:

Dr. J. Hutchison Williams, Associate Dean, The Ohio State University, College of Medicine, Columbus (Check for $15,250.59).

Dr. Stephen P. Hogg, First District Councilor, accepting for the University of Cincinnati College of Medicine, Cincinnati (Check for $18,393.75).

Dr. John P. Kemph, Acting Dean, Medical College of Ohio at Toledo, Toledo (Check for $5,110.76).

Dr. Edgar Lee, representing Case Western Reserve School of Medicine, Cleveland (Check for $10,350.74).

Plaques and Certificates of Appreciation

Dr. William R. Schultz, Wooster, received a plaque in appreciation for his service to the Association, as retiring member of the Council.

A certificate of appreciation was presented to Dr. Frank F. A. Rawling, Toledo, for his service as a member of the Standing Committee on Judicial and Professional Relations.

The following retiring chairmen of special committees were honored: Dr. Maurice F. Leiber, Canton, Committee on Auditing and Appropriations and Committee on Private Practice; Dr. Sol Maggied, West Jefferson, Joint Advisory Committee on Sports Medicine; Dr. William R. Schultz, Wooster, Ohio Medical Indemnity Liaison Committee, and Dr. Jeanne H. Stephens, Oberlin, Committee on Nursing.

Dr. Frederick P. Osgood, Toledo, was presented a certificate of appreciation for his service to the Association, as a retiring member of the OSMA Delegation to the AMA.

Dr. Clarke then introduced Dr. William R. Schultz to present Life Active Membership pins to the following:

Dr. Chester H. Allen, Portsmouth; Dr. Henry C. Chalfant, Ashland; Dr. Vera Clem Chalfant, Ashland; Dr. Oscar W. Clarke, Gallipolis; Dr. Laurence L. Cockerille, Jr., Parma; Dr. Walter Daniel, Tiffin; Dr. John J. Gaughan, Cleveland; Dr. Carl J. Greever, Jackson; Dr. James L. Henry, Grove City; Dr. Paul A. Jones, Zanesville; Dr. William A. Millhon, Columbus; Dr. Thomas W. Morgan, Gallipolis; Dr. A. Burton Payne, Ironton; Dr. Kirkwood A. Pritchard, Paulding; Dr. Geeta Srinivas, Cleveland; Dr. Philip C. Stiff, Toledo, and Dr. Thomas C. Versic, Cincinnati.

Presentation of Distinguished Service Citation

Dr. John H. Budd, Cleveland, was named recipient of the Distinguished Service Citation. This citation was in recognition of his contribution to medicine as a family physician and as a member of the AMA Board of Trustees. Dr. Budd was given a standing ovation as he accepted the award and expressed his thanks.

Reference Committees Appointed

The following House of Delegates Reference Committees were appointed by the President:

Credentials of Delegates—Joseph A. Bonta, Chairman, Franklin County; George J. Schroer, Shelby County; Marvin McClellan, Hamilton County; Vincent T. La Maida, Cuyahoga County, and S. Baird Pfahl, Jr., Erie County.

President's Address—P. John Robechek, Chairman, Cuyahoga County; Richard L. Fulton, Franklin County; and Thomas W. Morgan, Gallia County.

Tellers and Judges of Election—Lawrence J. McCormack, Chairman, Cuyahoga County; John E. Albers, Hamilton County; Richard J. Wiseley, Lucas County; William E. Sovik, Mahoning County; and H. Judson Reamy, Tuscarawas County.

Resolutions Committee No. 1—Luther W. High, Chairman, Holmes County; Harry K. Hines, Hamilton County; W. J. Lewis, Montgomery County; Walter A. Daniel, Seneca County; B. Leslie Huffman, Lucas County; John H. Sanders, Cuyahoga County; W. Paul Kilway, Jr., Summit County; Philip T. Doughten, Tuscarawas County; Robert A. Ringer, Guernsey County; A. Burton Payne, Lawrence County, and Homer A. Anderson, Franklin County.

Resolutions Committee No. 2—Theodore J. Castele, Chairman, Cuyahoga County; James M. Smith, Butler County; Ernest H. Winterhoff, Clark County; David A. Barr, Allen County; Peter A. Overstreet, Lucas County; William Dorner, Jr., Summit County; Sanford Press, Jefferson County; Walter B. Devine, Muskingum County; Thomas P. Price, Jr., Gallia County; John N. Meagher, Franklin County, and A. Burney Huff, Wayne County.

Resolutions Committee No. 3—Roland A. Gandy, Jr., Chairman, Lucas County; Carl A. Minning, Clermont County; Isador Miller, Champaign County; Paul E. Lyon, Marion County; Alton W. Behm, Geauga County; E. Joel Davis, Stark County; A. John Antalis, Belmont County; John Kroner, Athens County; Chester H. Allen, Scioto County; Henry T. Lapp, Knox County, and Jon H. Cooperrider, Ashland County.

Election of Committee on Nominations

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations:

First District—Charles D. Feuss, Jr., Hamilton County.

(Continued on Next Page)

Second District—A. Robert Davies, Miami County.

Third District—Robert B. Elliott, Hardin County.

Fourth District—C. Douglass Ford, Lucas County.

Fifth District—Frederick T. Suppes, Cuyahoga County.

Sixth District—Emmett P. Monroe, Summit County.

Seventh District—Carl A. Lincke, Carroll County.

Eighth District—Frederick N. Karaffa, Licking County.

Ninth District—A. Burton Payne, Lawrence County.

Tenth District—Joseph A. Bonta, Franklin County.

Eleventh District—Harold F. Mills, Richland County.

Dr. Clarke then announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the Committee this year would be the delegate from the First District, Dr. Charles D. Feuss, Jr., Hamilton County.

President's Address

Mr. Page then introduced President Oscar W. Clarke, Gallipolis, who delivered his Presidential Address. (Text of the address appears on page 435.)

After the Address, the House gave Dr. Clarke a standing ovation.

Introduction of Resolutions

Dr. Clarke then called for the introduction of resolutions. He ruled that resolutions which had been presented within the 60-day time limit and had been distributed to the delegates in advance of the meeting could be introduced by reading of the title only. Fifty resolutions were introduced and were referred to the resolutions committees. A report from the Council on Resolutions 3-73 and 30-73 was also referred.

Report of the Committee on Emergency Resolutions

The Committee on Emergency Resolutions, consisting of the chairmen of the three resolutions committees, met to consider an emergency resolution submitted by the Stark County Medical Society. It was the opinion of the Committee that this resolution did not qualify as a justified Emergency Resolution. It was noted that the content of the resolution was covered in resolutions from other counties.

By official action, the report was adopted.

House Recessed

The House then recessed until the final session, 3:30 p.m., Wednesday, May 15.

MINUTES OF THE FINAL SESSION

The final business session of the House of Delegates convened at 3:30 p.m., Wednesday, May 15, at the Sheraton-Cleveland Hotel.

Introduction of Out-of-State Guests

Dr. Clarke introduced the following out-of-state guests: Dr. John A. Martin, Roanoke, President of the Medical Society of Virginia, and Dr. William E. Gilmore, Parkersburg, President-Elect of the West Virginia State Medical Association.

Presentation of Special Award

Dr. Clarke presented a special award to Dr. Victor C. Laughlin, Cleveland, for his outstanding contribution, as Art Show Chairman.

Report of Credentials Committee

Dr. Joseph A. Bonta, Franklin County, Chairman of the Committee on Credentials, reported out of 171 delegates eligible to vote, 154 were seated.

Committee on President's Address

Dr. Clarke then called for the report of the Reference Committee on President's Address (see page 435), which was presented by Dr. P. John Robechek, Cuyahoga County, Chairman of the Committee. The report read as follows:

"President Clarke's address was devoted to the principal problems facing medical practitioners and the entire health care team at the present time. Fortunately, Dr. Clarke's remarks provided an excellent extension to the opening interlude of this House, but proved that Ohio has a positive approach to the many questions posed in that opening interlude.

"A sizeable portion of his address was directed to the divisive issues of MAI and PSRO, and he effectively described the differences between MAI's Peer Review System and the Professional Standard Review Organizations envisaged by the federal government.

"Dr. Clarke reviewed the development of the MAI Peer Review Systems which provides that peer review shall be done for the patients by their doctors on behalf of all patients. He also reviewed

the previously stated position of this House of Delegates which remains consistent with OSMA's long-held opinion that the quality of medical care cannot be allowed to deteriorate because of governmental or third-party intervention.

"The President ably discussed the unlikely possibility of repeal, the likely possibility of success in amending the provisions of the Bennett Amendment, and went on to state that Ohio's Peer Review system will continue to be operated in order to demonstrate the superior care rendered to the patients of Ohio by their physicians.

"In the event that the federal government attempts to distort or interfere with Ohio's Peer Review System, Dr. Clarke pointed out that it was the intention of this Association, 'to secure an injunction from a federal court and have a federal judge, not a bureaucrat in Washington or Columbus, tell us in what manner we err.'

"The report of the Governor's Task Force on Health Care and the Dissenting Minority Report by Drs. Schultz and Lancione were presented by President Clarke, and the dangers of implementation of the bureaucratic approaches suggested by the Task Force were delineated carefully and well by him.

"He concluded his remarks by pointing out that Americans have the greatest personal access to the health care system of any people in the world, and that the fact that they do not take advantage of that opportunity for access does not equate with the thesis that there is something wrong with the system or systems.

"President Clarke also reiterated the fact that the people of the State of Ohio will not tolerate a medical and health czar and the resultant effects on their lives.

"The Committee wishes to commend Dr. Clarke for the content of his speech, for the manner of his delivery, and most of all, for his unswerving dedication to the private practice of medicine during this past, most stressful year: Thomas W. Morgan, Gallia County; Richard L. Fulton, Franklin County; P. John Robechek, Cuyahoga County, Chairman."

On a motion made and seconded, the House of Delegates, by official action, approved the report of the Reference Committee on President's Address.

Election of President-Elect

Dr. Clarke called for nominations for the office of President-Elect. The Stark County Medical Society placed in nomination the name of Dr. Maurice F. Lieber, Canton, Stark County, Sixth District Councilor of the Association. The nomination was duly seconded by Drs. P. John Robechek, Frank H. Mayfield and E. Joel Davis.

There were no other nominations and the House voted to elect Dr. Lieber by acclamation.

Report of Nominating Committee

Dr. Charles D. Feuss, Jr., Delegate, Hamilton County, Chairman, Committee on Nominations presented the report of the Nominating Committee, as follows:

Councilors

First District

As Councilor of the First District to succeed himself, the Committee placed in nomination Dr. Stephen P. Hogg, of Cincinnati. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Hogg was declared reelected Councilor of the First District for a term of two years, 1974-1975 and 1975-1976.

Third District

As Councilor of the Third District to succeed himself, the Committee placed in nomination Dr. John C. Smithson, of Findlay. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Smithson was declared reelected Councilor of the Third District for a term of two years, 1974-1975 and 1975-1976.

Fifth District

As Councilor of the Fifth District to succeed himself, the Committee placed in nomination Dr. John J. Gaughan, of Cleveland. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Gaughan was declared reelected Councilor of the Fifth District for a term of two years, 1974-1975 and 1975-1976.

Sixth District

As Councilor of the Sixth District to succeed Dr. Maurice F. Lieber, Canton, the Committee placed in nomination Dr. C. Edward Pichette, of Youngstown, Ohio, and Dr. Robert R. Clark, of Akron. Both nominations were duly seconded and a secret ballot taken. Dr. C. Edward Pichette was declared elected on the first ballot to the unexpired portion of the term of Dr. Lieber (1974-1975).

Seventh District

As Councilor of the Seventh District to succeed himself, the Committee placed in nomination Dr. Robert E. Rinderknecht, of Dover. The nom-

ination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Rinderknecht was declared reelected Councilor of the Seventh District for a term of two years, 1974-1975 and 1975-1976.

Ninth District

As Councilor of the Ninth District to succeed himself, the Committee placed in nomination Dr. Thomas W. Morgan, of Gallipolis. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Morgan was declared reelected Councilor of the Ninth District for a term of two years, 1974-1975 and 1975-1976.

Eleventh District

As Councilor of the Eleventh District to succeed himself, the Committee placed in nomination Dr. Robert G. Thomas, of Elyria. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Thomas was declared reelected Councilor of the Eleventh District for a term of two years, 1974-1975 and 1975-1976.

AMA Delegates

Dr. Feuss then presented the nominees for the office of delegate to the American Medical Association for a term of two years beginning January 1, 1975: Drs. Richard L. Meiling, Columbus; Lawrence C. Meredith, Oberlin; Robert N. Smith, Toledo, and Robert E. Tschantz, Canton. The nominations were duly seconded and there were no further nominations from the floor. Drs. Meiling, Meredith, Smith and Tschantz were reelected delegates to the American Medical Association for a term of two years, beginning January 1, 1975.

AMA Alternate Delegates

For alternate delegates to the American Medical Association for a term of two years beginning January 1, 1975, the Nominating Committee placed in nomination the names of Drs. Dwight L. Becker, Lima; B. Leslie Huffman, Jr., Maumee; H. William Porterfield, Columbus; John E. Albers, Cincinnati; John J. Gaughan, Cleveland and James G. Roberts, Akron. (Dr. Roberts withdrew his name from the slate of nominations.) The nominations were duly seconded and there were no further nominations from the floor. A secret ballot was taken and the following were elected alternate delegates to the American Medical Association for a term of two years, beginning January 1, 1975: Drs. Becker, Huffman, Porterfield and Albers.

Dr. Albers was also elected alternate delegate for a term ending December 31, 1974 to fill a vacancy created due to the death of Dr. David Fishman.

Report of Resolutions Committee No. 1

Dr. Luther W. High, Holmes County, reported for Resolutions Committee No. 1, of which he was chairman. The report read as follows:

"Resolutions Committee No. 1 was assigned a total of 16 resolutions for consideration. Resolutions 1, 2 and 7 were identical and were, therefore, considered as one resolution. Resolutions 10 and 13 were also identical and were considered as one resolution. All persons present at the open meeting were given an adequate amount of time to present their testimony, either for or against the resolutions presented. In addition, staff members of the OSMA gave information pertinent to the resolutions.

"The Committee had been divided into Subcommittees by the Chairman, and at the conclusion of the open hearings the entire Committee met in Executive Session. Following this, the Subcommittees were asked to give additional study to the resolutions assigned to them and the Committee in its entirety met in the afternoon and received the recommendations of the Subcommittees. These were again discussed by the entire Committee and the report as presented to the House at this time was completed. On two occasions, the vote of the Committee was divided equally and the Chairman cast the deciding vote."

RESOLUTION NO. 1-74
New Councilor District

"Resolution No. 1-74 was considered and after considerable discussion, the following conclusions were reached. While recognizing the differences represented in suburban, rural and metropolitan medical practice, and the problems existing in communication and distance, we doubt the wisdom of further division of districts for the following reasons: (1) increased cost locally and on the state level, (2) increased size of Council, and (3) precedence set by fragmentation which could logically occur in several other areas.

"It is hoped that there may be improvement in communication between Councilors and their county societies to assure adequate representation of all views. It was pointed out in the discussion that some counties have not been visited by their Councilor in many years. It is, therefore, the

unanimous opinion of this Committee that Resolution No. 1-74 not be adopted, and, Mr. President, I so move."

By official action, **Resolution No. 1-74 was rejected.**

RESOLUTION NO. 3-74

Circumvention of Democratic Process

"Resolution No. 3-74, submitted by Ross County, was then considered. While the Committee understood the intent of this resolution, it was their opinion that the amendment was not presented in the proper manner for consideration by the House of Delegates according to Chapter 15, Section 1, of the Bylaws of the OSMA. A Substitute Resolution is, therefore, being presented which embodies the intent of the Ross County Medical Society in presenting this resolution.

"The Resolution Committee considered Resolution No. 3-74 and offers instead the following substitute resolution:"

AMENDED SUBSTITUTE RESOLUTION NO. 3-74

WHEREAS, At the present time all resolutions of an ethical nature involving professional relations are referred to The Council without discussion pursuant to Chapter 7, Section 1, of the Bylaws, and

~~WHEREAS, The Ross County Medical Society's Resolution No. 3-74 regarding medical ethics of signing the provider agreement with the Ohio Department of Public Welfare was submitted to the 1973 Ohio State Medical Association's House of Delegates and was referred to Council because of the above named provisions of the Constitution and Bylaws, and~~

WHEREAS, It is the intent of the Ohio State Medical Association to provide hearings on any resolutions submitted in the proper manner, AND FORMULATE ACTION THEREON AT THE EARLIEST PRACTICAL MOMENT, PROVIDED SUCH RESOLUTION DOES NOT CONCERN THE ETHICS OF INDIVIDUAL PHYSICIANS OR GROUPS OF PHYSICIANS, THEREFORE, BE IT

RESOLVED, That the Constitution and Bylaws of the Ohio State Medical Association be appropriately amended to allow all future resolutions to be discussed in reference committees and voted upon by the House of Delegates, PROVIDED THEY DO NOT CONCERN THE ETHICS OF INDIVIDUAL PHYSICIANS OR GROUPS OF PHYSICIANS, recognizing the prerogative of the House of Delegates to enter into Executive Session or on their own initiative to refer to the Judicial and Professional Relations Committee matters of sensitive or delicate nature, and BE IT FURTHER

RESOLVED, THAT MATTERS CONCERNING ETHICS OF INDIVIDUAL PHYSICIANS OR GROUPS OF PHYSICIANS WILL CONTINUE TO BE REFERRED TO COUNCIL DIRECTLY AS IN THE PAST, AND BE IT FURTHER

RESOLVED, That a copy of this resolution be referred to a special committee on Constitution and Bylaws to be appointed by the President for preparation of an appropriate resolution containing specific language amending the Constitution and Bylaws for introduction at the next meeting of the House of Delegates.

"Mr. President, I move the adoption of this Substitute Resolution No. 3-74."

By official action, the House **voted to amend Substitute Resolution No. 3-74, as indicated by the strike-out deletions, and by the additions set forth in capital letters, then adopted it.**

RESOLUTION NO. 4-74

Appointment of Members to Resolutions Committees

"Resolution No. 4-74 regarding appointment of members to resolutions committees was then considered.

"A Substitute Resolution No. 4-74 is submitted by the Reference Committee. The members of the Committee discussed at great length the many commendable suggestions contained in Resolution No. 4-74. It especially applauds the provision that the Ohio State Medical Association should make every effort to reflect and enact the desires of its individual members and to provide equitable and equal representation on reference committees. However, it was felt by the Reference Committee that the method presented by the resolution was somewhat cumbersome and did not reflect a practical solution at this time. Therefore, the following Substitute Resolution is submitted for consideration by the House:"

SUBSTITUTE RESOLUTION NO. 4-74

WHEREAS, The only voice that the individual physician member in Ohio has at the Annual Meeting of the OSMA House of Delegates is through the Delegates whom he has selected from his own county to represent him, and

WHEREAS, Each Delegate is both informed by and responsive to the individual members of his own county medical society who elect him to represent them, and

WHEREAS, Resolutions presented before the House of Delegates are the written testimony of the thoughts and actions of the individual members working together in their county medical society meetings, and

WHEREAS, It would be advantageous for members of the reference committees to be as well informed on the subjects they are to consider as possible, THEREFORE, BE IT

RESOLVED, That the Reference Committee be appointed by the President of the Ohio State Medical Association after consultation with the Councilor of the Councilor District involved, and BE IT FURTHER

RESOLVED, That the assignment of all resolutions except emergency resolutions to the committees on resolutions be published and distributed concurrently with the text of the resolutions which are mailed to the Delegates and Alternates, and BE IT FURTHER

RESOLVED, That Chapter 4, Section 4, of the Bylaws be appropriately amended to effect these changes in procedure for the appointment of resolutions committees and the assignment of resolutions to the said committees, and BE IT FURTHER

RESOLVED, That a copy of this resolution be referred to a special committee on Constitution and Bylaws and to be appointed by the President for preparation

of an appropriate resolution containing specific language amending the Constitution and Bylaws for introduction at the next meeting of the House of Delegates.

"Mr. President, I move the adoption of the Substitute Resolution No. 4-74."

By official action, the House **voted to reject Substitute Resolution No. 4-74,** and by official action, the House voted to reject **Resolution No. 4-74, as it was originally submitted.**

RESOLUTION NO. 5-74
Dues Increase

"The Committee feels that it is imperative to make a dues adjustment that will be adequate for several years and make possible the most effective function of the state organization. It is, therefore, recommended that Resolution No. 5-74 be adopted as introduced with one change. In the final RESOLVE, the annual dues of active members and associate members shall be increased to $125 instead of $110. The amended resolution will read as follows:

AMENDED RESOLUTION NO. 5-74

WHEREAS, The Ohio State Medical Association is currently operating at a deficit; and

WHEREAS, The Association is understaffed to meet the obligation to its members; and

WHEREAS, This Association needs now a full-time Department of State Legislation to cope with a State Legislature which is in continuous session; and

WHEREAS, The Association must establish a full-time field service department to bring immediate assistance to the non-metropolitan county medical societies and to strengthen the autonomy of their operations; and

WHEREAS, The rising costs of conducting Association business must be met—postage costs increasing by 18%; travel costs escalating due to fuel problems; paper shortages and rising printing costs—in order to keep communications open; and

WHEREAS, Overly funded state and national governments have organized hundreds of agencies which have turned out millions of words, promulgated countless rules and regulations, generally aimed at developing and implementing plans to take over and control the practice of medicine; and

WHEREAS, Government at legislative, administrative and judicial levels, as well as the public, must hear medicine's answer to the proposals churned out by such agencies; and

WHEREAS, It is necessary to acquire additional staff personnel to work with the Association's committees who develop policies on these proposals for consideration of the House and of the Council; and

WHEREAS, During the next several years costly litigation will be necessary in a number of areas in order to protect the rights of physicians, making necessary the accumulation of funds for legal expense; and

WHEREAS, Modernization of the OSMA membership system to electronic data processing equipment and the word processing system by purchase of an offset press involve considerable capital expenditure; and

WHEREAS, The "word battle" with governmental agencies necessitates the expansion of the Public Relations Department, which now consists of only one staff executive and one secretary, both on a part time assignment to Public Relations; and

WHEREAS, These improvements in the structure of organized medicine must be accomplished forthwith or medicine's house will be destroyed; THEREFORE, BE IT

RESOLVED, That the annual dues of active members and associate members be increased to $125, effective January 1, 1975, pursuant to the authority granted to this House of Delegates by Chapter 2, Section 1, of the Bylaws of this Association.

By official action, the House **voted to adopt Amended Resolution No. 5-74.**

RESOLUTION NO. 6-74
Public Relations Levy

"The Committee is in complete agreement with the resolution as submitted, however, in the opinion of this Committee the passage of Resolution No. 5-74 eliminates the need for the assessment as stated in the final RESOLVED of Resolution No. 6-74. It is therefore recommended that the final RESOLVED be deleted and that the resolution as presented with this deletion, be adopted. Mr. President, I so move."

AMENDED RESOLUTION NO. 6-74

WHEREAS, Progressive pressures from third parties, i.e., insurance carriers, social interests, and malpractice potentials are diverting the energies of formerly and currently practicing physicians and also of available monies from the clinical care of patients; and

WHEREAS, There is every indication that further changes will ensue to increase this diversion to the further detriment of the clinical care of patients unless these pressures are dealt with, and

WHEREAS, The patient is in a much better position, by weight of numbers, to exert effective political counterpressure; and

WHEREAS, The public is apparently relatively unaware of the imminence of further changes and implications of these as hazards for its members' clinical care; NOW, THEREFORE, BE IT

RESOLVED, That the Committee on Public Relations of the Ohio State Medical Association be instructed to embark on an extensive publicity campaign to inform patients and the public of the hazards to their continuing medical care posed by present and proposed programs.

By official action, **Amended Resolution No. 6-74 was adopted.**

RESOLUTION NO. 8-74
Constitution and Bylaws of OSMA

"The Committee thoroughly discussed this resolution and was of the opinion that the paragraphs under question were not in violation of the principle of medical ethics and so Mr. President, I move that Resolution No. 8-74 not be adopted."

By official action, the House **voted to reject Resolution No. 8-74.**

RESOLUTION No. 9-74

Information and Education Serve Freedom

"Resolution No. 9-74 was considered and a Substitute Resolution is presented by the Committee at this time."

SUBSTITUTE RESOLUTION NO. 9-74

WHEREAS, There is a basic need to disseminate information to all members of the Ohio State Medical Association, and

WHEREAS, There is a desire of many members who are not Delegates or Alternates or county officers to receive copies of the complete text of the resolutions to be considered by the House of Delegates at the Annual Meeting of the Ohio State Medical Association, and

WHEREAS, The publication of the complete text of the resolution in *The Journal* of the Ohio State Medical Association fraught with legal complications, and

WHEREAS, The cost of sending the complete text of the resolutions to every member of the Ohio State Medical Association, when no interest is manifested, would be an expense that might not well be justified, THEREFORE BE IT

RESOLVED, That provisions be made for any member of the Ohio State Medical Association to receive, upon request, a copy of the complete text of the resolutions to be considered at each Annual Meeting, and it suggested that this be implemented by a tear-off sheet in the OSMAgram designed to make such a request by a member both easy and uncomplicated.

"Mr. President, I move adoption of the Substitute Resolution No. 9-74."

By official action, **Substitute Resolution No. 9-74 was adopted.**

RESOLUTION NO. 10-74

Professionalism

"It was the opinion of the Committee that the resolution had merit. It is therefore recommended that the resolution as presented should be adopted, and, Mr. President, I so move."

RESOLUTION NO. 10-74

Professionalism

(By Alford C. Diller, M.D., Delegate, Van Wert County Medical Society)

WHEREAS, Medical practitioners, individually and collectively, are under increasing criticism and pressure for changes; and

WHEREAS, The professionalism of the medical practitioner is being questioned; and

WHEREAS, There is increasing need to take a more responsible stance to regulate and discipline our own ranks; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association create an ad hoc committee composed of representatives of the various disciplines of medicine to study and delineate both non-negotiable and negotiable components of professionalism as applied to the practice of the medical arts and sciences; and BE IT FURTHER

RESOLVED, That these non-negotiable and negotiable components be used as guidelines for the conduct of our members, the establishment of relationship with patients, and for negotiation with various third parties including governmental agencies.

By official action, **the House voted to adopt Resolution No. 10-74.**

RESOLUTION NO. 11-74

To Commend the Ohio Foundation for Medical Care

"Resolution No. 11-74 was considered and in the opinion of this Committee this resolution should be adopted. Mr. President, I so move."

RESOLUTION NO. 11-74

To Commend the Ohio Foundation for Medical Care

(By John N. Meagher, M.D., Delegate, Academy of Medicine of Columbus and Franklin County)

WHEREAS, The Ohio State Medical Association House of Delegates, at its Annual Meeting in 1973, adopted a policy to "Develop OFMC (The Ohio Foundation for Medical Care) to assist Local and Regional Medical Associations in the development and implementation of local and regional Foundations for Medical Care;" and

WHEREAS, The OFMC was incorporated in January of 1974 and is now beginning to implement this Resolution; and

WHEREAS, The officers and members of the OFMC Board of Trustees have shown great dedication to organized medicine by serving on the Board; THEREFORE, BE IT

RESOLVED, That the OSMA House of Delegates commend the OFMC and its Board of Trustees for its activities in the field of developing alternatives to closed panel HMO's; and BE IT FURTHER

RESOLVED, That the House of Delegates encourage the OFMC to continue its work in assisting local areas to develop local and regional foundations for medical care.

By official action, **Resolution No. 11-74 was adopted.**

RESOLUTION NO. 12-74

Affiliate Membership

"Resolution No. 12-74 was approved by the Committee with the additional RESOLVED. A final RESOLVED will then be added to this resolution:"

The resolution with the added final RESOLVED will, therefore, read:

AMENDED RESOLUTION NO. 12-74

Affiliate Membership

(By John J. Gaughan, M.D., Fifth District Councilor, and the Academy of Medicine of Cleveland)

WHEREAS, Medical society executives are closely affiliated to the medical profession through their service to medical organizations; and

WHEREAS, Medical society executives have demonstrated their loyalty to the ideals and policies of medical organizations and the profession; and

WHEREAS, The American Medical Association in recognition of this service has admitted medical society

executives to affiliate membership in the A.M.A.; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association create a class of membership to be called "Affiliate Members," and BE IT FURTHER

RESOLVED, That executives of the OSMA, county medical societies, and other medical organizations and specialty societies in Ohio be eligible for Affiliate Membership in the Ohio State Medical Association; and BE IT FURTHER

RESOLVED, That Article III, Section I of the Constitution be amended by adding (7) "Affiliate Members;" and BE IT FURTHER

RESOLVED, That Chapter I, Section II of the Bylaws be amended to add paragraph (h) "Affiliate Members." Executives of the Ohio State Medical Association, county medical societies and other medical organizations and specialty societies in Ohio are eligible for "Affiliate Membership" in the Ohio State Medical Association. Such "Affiliate Membership" shall be at the pleasure of The Council of the Ohio State Medical Association, and BE IT FURTHER

RESOLVED, That a copy of this resolution be referred to a special committee on Constitution and Bylaws to be appointed by the President for preparation of an appropriate resolution containing specific language amending the Constitution and Bylaws for introduction at the next meeting of the House of Delegates.

"Mr. President, I move that Resolution No. 12-74 be adopted with the additional RESOLVED as stated."

By official action, **the House voted to adopt Amended Resolution No. 12-74.**

RESOLUTION NO. 14-74

Governor's Task Force on Health Care

"Resolution No. 14-74 was considered by the Committee and it is the unanimous opinion of this Committee that this resolution as presented shall be adopted."

AMENDED RESOLUTION NO. 14-74

Governor's Task Force on Health Care

(By the Summit County Medical Society)

WHEREAS, The Governor of the State of Ohio appointed a special Task Force on Health Care in March, 1973, to examine all aspects of health care in Ohio and to formulate a health care strategy for the 1970's; and

WHEREAS, This Task Force worked on a committee basis, meeting only twice in full, once to organize and once again to receive the full Report as written by the Task Force Executive Committee; and

WHEREAS, The full Task Force Report, adopted in December of 1973, includes many suggestions that would drastically change the mechanisms of health care delivery in Ohio, including consolidation and state take-over of all Blue Cross plans; major state control of professionals and institutions through certification of need and hospital licensure legislation; artificial financial stimulation of pre-paid, closed-panel, group practices; placement of a non-physician on the State Medical Board; and other suggestions; and

WHEREAS, The Governor's Task Force Report calls for increasing governmental involvement and manipulation of Ohio's health care delivery systems; and

WHEREAS, PROVISIONS OF PUBLIC LAW 92-603—SPECIFICALLY SECTION 1122 DEALING WITH LIMITATIONS OF EXPENDITURE OF FEDERAL HEALTH FUNDS—MAKE FEASIBLE THE GOVERNOR'S IMPLEMENTATION OF THE ABOVE; AND

WHEREAS, Increased governmental involvement over the last two decades has resulted in directly increased health care costs; and

WHEREAS, William R. Schultz, M.D., acting as a representative of the OSMA, and Peter Lancione, M.D., have filed a Minority Report which has been published along with the Task Force Report, outlining areas of agreement as well as areas of disagreement; and

WHEREAS, That Minority Report concludes that "The free and independent people of the State of Ohio will not tolerate a medical and health czar and this concept's effect on their personal lives;" THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association endorse the Schultz-Lancione Minority Report to the Governor's Task Force on Health Care Report; and BE IT FURTHER

RESOLVED, That the OSMA call upon the Governor of Ohio to abandon and disregard sections of the Task Force Report that interfere with the rights of Ohio citizens to seek physicians of their own choice; and BE IT FURTHER

RESOLVED, THAT THE OSMA CALL UPON THE GOVERNOR NOT TO IMPLEMENT PROVISIONS OF PUBLIC LAW 92-603, SPECIFICALLY SECTION 1122, IN ANY MANNER THAT MIGHT IMPAIR OR INTERFERE WITH QUALITY HEALTH CARE DELIVERY; AND BE IT FURTHER

RESOLVED, That the OSMA continue to strive to promote quality health care delivery systems without excessive governmental involvement because increasing governmental involvement results in depersonalization of medical care, medical decisions by regulation rather than by professional judgment exercised in the individual patient's best interests, invasion of privacy of the patient and the patient-physician relationship, and increased health care costs.

By official action, the House **voted to amend Resolution No. 14-74, as indicated by the additions set forth in capital letters, then adopted it.**

RESOLUTION NO. 15-74

Budget Publication

The Committee recommends that there be no change in the WHEREAS as presented in the original resolution and that the RESOLVED be stated as follows:

AMENDED RESOLUTION NO. 15-74

Budget Publication

(By the Academy of Medicine of Cincinnati)

WHEREAS, The members of the Ohio State Medical Association are deeply concerned about the finances of this organization, especially in regard to increasing Dues; and

WHEREAS, The membership of this organization should be the final source in the consideration of the expenditure of their monies; and

WHEREAS, The local Councilor-Districts represent the membership in the local action of the organization; THEREFORE, BE IT

RESOLVED, That Chapter 7, Section 5, of the Constitution and Bylaws be appropriately amended to require the publication and distribution of the annual budget to all Delegates and Alternates at least 90 days prior to the Annual Meeting, and BE IT FURTHER

RESOLVED, That a copy of this resolution be referred to a special committee on Constitution and Bylaws to be appointed by the President for preparation of an appropriate resolution containing specific language amending the Constitution and Bylaws for introduction at the next meeting of the House of Delegates.

"Mr. President, I move adoption of Resolution No. 15-74 with the change as stated."

By official action, the House **voted to adopt Amended Resolution No. 15-74.**

RESOLUTION NO. 16-74

Compulsory Post Graduate Medical Educational Program

"The Committee felt that a change in the wording of the RESOLVED should be made. There is no change in the WHEREAS', and the Amended Resolution will, therefore, read:

AMENDED RESOLUTION NO. 16-74

Compulsory Post Graduate Medical Educational Program

(By the Academy of Medicine of Cincinnati)

WHEREAS, The advancement of medical education is of vital importance to this organization and to each of the physician-members and must not be neglected; and

WHEREAS, Each of the specialty societies have set up comprehensive examination and prerequisites to enter a specialty and become Board-Certified as a specialist; and

WHEREAS, Hospital Staff-privileges are granted to a physician only upon meeting the prerequisite requirements of a credentials committee through certification of apprenticeship in those fields where expertise has been proven; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association reaffirm its strong opposition to any discriminatory government rules and regulations regarding compulsory formal post graduate medical education and re-examination for licensure, and BE IT FURTHER

RESOLVED, That assessment of a physician's competence, by his performance at the local level, be a preferable technique.

"Mr. President, I move adoption of Amended Resolution No. 16-74."

By official action, the House **voted to adopt Amended Resolution No. 16-74.**

"Mr. President, I move that the report of the Resolutions Committee No. 1, as a whole, be adopted.

"Mr. President and fellow Delegates:

"Resolutions Committee No. 1 adopted a somewhat different procedure than has been done in the past in that Subcommittees were appointed by the Chairman. I feel that it is the opinion of all members of the Committee that this worked very well and gave more careful consideration to the views presented by those whose testimony was heard. The Committee feels that the resolutions adopted, those disapproved and those changed, are in the best interests of the Ohio State Medical Association and its component societies and members. This House is deeply indebted to the members of this Committee and for their devoted labors in your behalf.

"On behalf of the Committee, I wish to thank legal counsel of the OSMA, Mr. James E. Pohlman, for his assistance and knowledgeable advice. We are also indebted to the capable staff of the Ohio State Medical Association. I must especially thank Katherine Wisse and Sandra Barrett for their help for presenting information to the Committee and for compiling this report for presentation."

The following were members of the Committee: Harry K. Hines, Hamilton County; W. J. Lewis, Montgomery County; Walter A. Daniel, Seneca County; B. Leslie Huffman, Lucas County; John H. Sanders, Cuyahoga County; W. Paul Kilway, Jr., Summit County; Philip T. Doughten, Tuscarawas County; Robert A. Ringer, Guernsey County; A. Burton Payne, Lawrence County; Homer A. Anderson, Franklin County; Luther W. High, Chairman, Holmes County.

The report of Resolutions Committee No. 1, as a whole, as amended, was approved by the House.

Report of Resolutions Committee No. 2

Dr. Theodore J. Castele, Cuyahoga County, reported for Resolutions Committee No. 2, of which he was chairman. The report read as follows:

"The Committee met and considered the items referred to it. We met in open session from 8:30-12:00 and from 1:30-4:00 p.m. During this time a great deal of testimony was heard and considered. The members of the Association conducted themselves in an exemplary manner and orderly testimony was given.

"Resolutions 17, 21 (Resolves 1, 2 & 4), 22, 23, 25, 28, 29, 30, 32, 33 and 35 (Resolves 1 & 3) concerned PSRO and were discussed together. We heard:

"1. That P.L. 92-603 was a bad law and as such should be repealed outright. The OSMA was exhorted to join other organizations in asking for repeal.

"2. We heard that repeal was not possible or wise, but that P.L. 92-603 was a bad law and should be amended to produce changes making the law acceptable to the medical profession.

"3. We heard that P.L. 92-603 was a bad law but that we should strive within its frame-

work to make it work for the benefit of our patients.

"4. Finally, we heard that we should exercise our option under the law and choose not to volunteer to implement PSRO as it now stands.

"Throughout the discussion the membership agreed that Peer Review was needed and good, but that PSRO under P.L. 92-603 as it now stands was unwise and dangerous. Also throughout the deliberations was the plea for the OSMA to develop a unified and solid approach to the problem without responding to pressures from Government. Action, rather than reaction, was called for in loud tones.

"Resolutions 18, 21 (Resolve #3), 24, 27, 31, 34, 35 (Resolve #2) all concerned Medical Advances Institute and were discussed collectively. From this discussion came the thoughts that MAI was suspected of becoming an agent of the Federal Government, that MAI was going to control private medical practice. On the positive side, MAI was commended for doing a difficult job, was supported in its peer review functions, was lauded for its innovative use of modern technologies and was encouraged in its support of local medical groups who wish to conduct superior, valid, high quality Peer Review. MAI was condemned for its early promulgations but recognition was given to the fact that it has evolved and matured into a superior system for clinical Peer Review. It was pointed out that local groups would do the review for self-assessment and education and that MAI provided only the mechanics for the job. Caution concerning problems with confidentiality and information retrieval by unauthorized persons was discussed. We were informed that the best possible safeguards were employed in the system to reduce this possibility to a minimum.

"The identification of quality medical care and the discovery of exceptions for local consideration without the cost containment function were acceptable to most who testified.

"Considered separately were Resolutions 19 and 20 concerning Preadmission Certification and Standardized Medical Insurance forms.

"After a day-long discussion from the floor, the members of Resolutions Committee No. 2 met in Executive Session for many hours. Resolutions numbered 17 through 35 were considered. Because of considerable overlap and replication these Resolutions were grouped wherever possible and substitution Resolutions are presented below.

"Because a member of the Resolutions Committee volunteered a segment of debate in the day-long discussion relative to some of the Resolutions, and at the suggestion of one of the members of the audience, his continued position on the Committee was considered, the members of this Committee felt that explaining a point of view during the meeting did not represent conflict of interest and that he should remain a member of the Committee.

"We believe it is important to note that the day-long discussions could be crystallized into several separate groups of opinion. It is the desire and intent of this Committee to reflect as accurately as possible the key issues.

"It is an inescapable conclusion that our membership is opposed to any concept of Federal Government controlled or operated medical care system which subjects physicians to Government directive in the delivery of quality medical care or subjects patients to any threat, implied or real, of any degree of violation of ethical physician-patient relationship. Further, it was unanimously believed that in no way could Government controlled or operated medical care delivery be more efficient or more effective than that which we have already. To wit, the Post Office, Government subsidy programs, Veterans' Administration hospitals, Foreign Aid, the present Welfare system, the National Debt and the Medicare program are not really shining examples of Government efficiency and cost control. As a result of this discussion, the Committee presents below composite Resolutions in reference to P.L. 92-603.

"Next the various Resolutions and testimony relative to MAI were discussed by the Committee. It was clearly realized that MAI, as directed by the House of Delegates of OSMA has indeed developed a sophisticated system of Peer Review to be employed by licensed, practicing physicians. The concensus of discussion was clearly in favor of clinical Peer Review done by local physician groups. The Committee furthermore believes unanimously that MAI's efforts should not be wasted and MAI should not be abandoned. The question of confidentiality with the MAI system was discussed and the Committee felt that proper safeguards were being employed by MAI.

"We are grateful to our colleagues for the opportunity to have served them and only hope that we have fulfilled our obligation of fair and impartial representation of their deliberations.

"The Committee recognizes the need for an end to equivocation and the further need for clear cut policy decisions by the House of Delegates regarding these issues and, therefore, recommends the following substitute resolutions:"

AMENDED SUBSTITUTE RESOLUTION 28-74

Repeal of P.L. 92-603

(Substitute for 17, 21, 22, 25, 26, 28, 29, 30, 32, 33)

WHEREAS, There is no crisis in the quality of medical care in America today, and

WHEREAS, The American public deserves the best quality medical care in the history of the world, and

WHEREAS, The quality of medical care is improving daily, and

WHEREAS, The Federal Government has recently enacted Public Law 92-603 to regulate the health care system of this country through a PSRO device which ostensibly is to control quality, and

WHEREAS, The medical profession has the highest ethical standards of any profession in the world, and has reviewed the quality of care since ancient times and continually seeks to improve that review procedure, and

WHEREAS, The PSRO provision of P.L. 92-603 is onerous and deleterious because (1) it is unnecessary; (2) it creates a monolithic bureaucracy which would govern the entire health care system under the Secretary of H.E.W.; and (3) can only lead to a reduction in quality care or a reduction in the improvement of quality care by the rationing of medical services, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association reject all portions of P.L. 92-603 pertaining to PSRO and that the OSMA and its component societies work toward changing the onerous portions of this law by efforts directed either at direct repeal or at repeal by amendment, and BE IT FURTHER

RESOLVED, THAT THE OSMA DELEGATES TO THE AMA AT THE 1974 ANNUAL SESSION OF THE AMA INSTRUCT THE HOUSE OF DELEGATES AND THE BOARD OF TRUSTEES OF THE AMA TO SEEK REPEAL OF THE PSRO LAW, EITHER BY DIRECT REPEAL OR BY REPEAL BY AMENDMENT. BE IT FURTHER

RESOLVED, That the OSMA engage in an active and vigorous public information campaign to inform the public and legislators of the potential loss of quality of patient care due to the deleterious effects of this law.

"Mr. Chairman, your Resolutions Committee recommends and I move adoption of Substitute Resolution 28-74."

By official action, the House voted to amend **Substitute Resolution No. 28-74 as indicated by the additions set forth in capital letters, then adopted it by acclamation.**

AMENDED SUBSTITUTE RESOLUTION 23-74

WHEREAS, P.L. 92-603 allows for but does not require physicians to form Professional Standards Review Organizations, and

WHEREAS, All portions of P.L. 92-603 pertaining to PSRO are objectionable to the medical profession, and

WHEREAS, The medical profession is committed to a high quality Peer Review system for all patients. THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association advise its members not to involve themselves in the implementation of ANY FORM OF GOVERNMENT-CONTROLLED PEER REVIEW AS EXEMPLIFIED BY THE PROFESSIONAL STANDARDS REVIEW SECTION OF P.L. 92-603 ~~in its present form,~~ however, BE IT FURTHER

RESOLVED, That OSMA advise the members of each component medical society to develop a uniform, effective, efficient, Peer Review system for all patients.

"Mr. Chairman, your resolutions Commitmittee recommends and I move adoption of Substitute Resolution 23-74."

By official action, the House voted to amend **Substitute Resolution No. 23-74 as indicated by the strike-out deletions, and by the additions set forth in capital letters, then adopted it.**

SUBSTITUTE RESOLUTION 34-74
MAI

(Substitute for 18, 24, 27, 31, 34)

WHEREAS, The medical profession has always reviewed its efforts on behalf of the patients, and

WHEREAS, This review by peers has constantly undergone improvement, and

WHEREAS, The Ohio State Medical Association is committed to a peer review system, and

WHEREAS, OSMA has repeatedly instructed MAI to create such a system, and

WHEREAS, MAI has responded with the most modern sophisticated peer review system in the world employing the most advanced technology available, and

WHEREAS, Ohio physicians have contributed vast amounts of energy and time without remuneration to this project, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association continue to support a meaningful and effective clinical Peer Review System as developed by Medical Advances Institute for use by all physicians for the benefit of their patients, and BE IT FURTHER

RESOLVED, That the more than one thousand physicians, both osteopathic physicians and surgeons and medical doctors, of Ohio who have contributed more than 22,000 man-hours to create a sophisticated Peer Review System be commended for their activities.

"Mr. Chairman, your Resolutions Committee recommends and I move adoption of Substitute Resolution 34-74."

By official action, the House voted to adopt **Substitute Resolution No. 34-74.**

AMENDED SUBSTITUTE RESOLUTION 35-74
Local Peer Review Systems

WHEREAS, All physicians are committed to a peer review system, and

WHEREAS, It is not feasible for all groups to develop a highly sophisticated system on their own, and

WHEREAS, OSMA has created such a sophisticated system through MAI, and

WHEREAS, OSMA also recognizes that peer review is more than a mechanical system and that it must be controlled by the local group of physicians; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association HOUSE OF DELEGATES direct THE COUNCIL OF THE OSMA TO REQUEST Medical Advances Institute that in Ohio it is only to act in a consultative and supportive role in assisting in the development and operation of a clinical Peer Review System in local areas or regions. This is to be accomplished only with the approval of the local medical organizations which are acceptable to the involved County Medical Society or Societies.

"Mr. Chairman, your Resolutions Committee recommends and I move adoption of Substitute Resolution 35-74.

(Continued on Next Page)

(PROCEEDINGS—*Contd.*)

"Mr. Chairman, that concludes the PSRO and MAI portion of the report."

By official action, the House **voted to amend Substitute Resolution No. 35-74 as indicated by the additions set forth in capital letters, then adopted it.**

"Resolution 19 regarding Preadmission Certification was then considered. The Resolution with certain editorial changes follows:"

AMENDED RESOLUTION NO. 19-74

Preadmission Certification

WHEREAS, The Secretary of the Department of Health, Education and Welfare has recently issued a set of proposed regulations that would require all non-emergency Medicare and Medicaid patients to be cleared by a Utilization Review Committee before admission to a hospital; and

WHEREAS, Such regulations would be a direct threat to the medical care of millions of patients served by Medicare and Medicaid and might deny hospital care to some individuals because they could not afford to pay for it from their own savings; and

WHEREAS, Such preadmission certification would be an affront to the dignity of the people served by Medicare and Medicaid; and

WHEREAS, Such decisions would not be made on the basis of an examination of the patient by a group of physicians but rather be based on review of some paper or admission form; and

WHEREAS, Any such denial of Medicare represents the violation of the spirit and letter of the Medicare-Medicaid Law which Congress established to provide medical care for the elderly and poor; and

WHEREAS, The Secretary of the Department of Health, Education and Welfare has no authority to amend the Medicare-Medicaid Law or reduce its benefits; and

WHEREAS, The Secretary's proposal is a direct and clear violation of Section 1801 of the Medicare-Medicaid Law; and

WHEREAS, The OSMA has informed the Secretary of the Department of the Health, Education and Welfare that it is advising its members not to participate in any manner in the implementation or operation of the regulations published in the Federal Register of January 9th which proposed preadmission review regulations for both Title XVIII and Title XIX; and

WHEREAS, The Board of Trustees of the AMA has declared its intention of seeking an injunction to block such proposed legislation; THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association advise the members of OSMA to continue to care for their patients to the best of their ability but to exercise their individual rights to refuse adamantly to lend their professional stature to the unethical program of Preadmission Certification.

"Mr. Chairman, your Resolutions Committee recommends and I move adoption of Resolution 19."

By official action, the House **voted to adopt Amended Resolution No. 19-74.**

"The Committee then considered Resolution 20 which with certain editorial changes reads as follows:"

AMENDED RESOLUTION NO. 20-74

Standardized Insurance Form

(By the Lorain County Medical Society)

WHEREAS, There is now a multiplicity of Insurance Forms requiring completion which place a large clerical burden on the physician's office; and

WHEREAS, Great conservation of energy and time could be afforded by a Standardized Insurance Form: THEREFORE, BE IT

RESOLVED, That the appropriate Committee or Committees of the Ohio State Medical Association devise a Standardized Form, or adopt or modify an existing form; and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association submit such a form to the Insurance Commissioner of the State of Ohio, working to secure his approval, and making it mandatory for insurance companies doing business in the State of Ohio to accept reports submitted on such a form.

"Mr. Chairman, the Committee recommends and I move referral of this Resolution to the Insurance Committee of the Council of the Ohio State Medical Association for further study and recommendations, and report back to the House of Delegates."

By official action, the House **voted to adopt Amended Resolution No. 20-74.**

"Mr. Chairman, that concludes the report of Resolutions Committee No. 2. We would like to express our sincere appreciation to the members of the Association who testified before this Committee with great patience. I am also personally extremely grateful for the time, energy, enthusiasm and great dedication of the Resolutions Committee members who discussed these Resolutions as impartially as possible and who helped to prepare this report.

"We thank our Legal Counsel, Mr. James Pohlman, and staff for their assistance in preparing this report.

"Mr. Chairman, I respectfully submit and move adoption of the report of Resolutions Committee No. 2, the members of which are: James M. Smith, Butler County; Ernest H. Winterhoff, Clark County; David A. Barr, Allen County; Peter A. Overstreet, Lucas County; William Dorner, Jr., Summit County; Sanford Press, Jefferson County; Walter B. Devine, Muskingum County; Thomas P. Price, Jr., Gallia County; John M. Meagher, Franklin County; A. Burney Huff, Wayne County; Theodore J. Castele, Chairman, Cuyahoga County.

The report of Resolutions Committee No. 2, as a whole, as amended, was approved by the House.

Report of Resolutions Committee No. 3

Dr. Roland A. Gandy, Jr., Lucas County, reported for Resolutions Committee No. 3, of which he was chairman. The report read as follows:

"Resolutions Committee No. 3 met in open session on Monday, May 13, 1974, and heard testimony relating to Resolutions No. 36-74 through No. 50-74, inclusive, and minutes of the March 13, 1974, meeting of the OSMA Judicial and Professional Relations Committee which included the Committee's deliberations relative to OSMA Resolution No. 3-73, Ethics of Charging Interest Rates, and OSMA Resolution No. 30-73, Ethical Status of Provider Agreement."

RESOLUTION NO. 36-74
Repeal of Prenatal Gonorrhea Testing
and
RESOLUTION NO. 48-74
Repeal of the Changes in the Ohio Prenatal Testing Law

"Taking into consideration testimony given at the open hearing, the Committee felt that testing for gonorrhea as required by this law is not effective, the yield of cases is extremely low, and that it is generally not possible to carry out the provisions of the law. Therefore, since Resolution No. 36-74 and Resolution No. 48-74 deal with the same subject matter, the Committee recommends that Resolution No. 48-74 be eliminated and that Resolution No. 36-74 be adopted without change and, Mr. President, I so move."

Resolution 36-74 reads as follows:

RESOLUTION NO. 36-74
Repeal of Prenatal Gonorrhea Testing
(By the Stark County Medical Society)

WHEREAS, Sections 3701.46 to 3701.50 of the Revised Code of the State of Ohio were amended, effective December 19, 1973, providing for mandatory examination of every pregnant woman for gonorrhea as part of her prenatal care; and

WHEREAS, The number of positive cases (yield) is extremely low in the general pregnant population; and

WHEREAS, Testing of pregnant women for gonorrhea should not, in any way, change the present procedures for prevention of ophthalmia neonatorum; NOW, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association request and actively support repeal of the amendments requiring mandatory examination of pregnant women for gonorrhea; and BE IT FURTHER

RESOLVED, That all physicians in the State of Ohio continue to test for gonorrhea in any patient when, in the opinion of the attending physician, such tests are indicated.

By official action, the House **voted that Resolution No. 48-74 be eliminated and that Resolution No. 36-74 be adopted.**

RESOLUTION NO. 37-74
Comprehensive Health Education in Ohio's Public Schools

"After much consideration of this resolution, the feeling of the Committee was that the compulsory element of this resolution should be deleted, and, we also felt that it was improper for the legislature to dictate curriculum. Therefore, it was the consensus of the Committee that this resolution should be amended as follows:

AMENDED RESOLUTION NO. 37-74

WHEREAS, Public health education offered through the schools with medical society cooperation and guidance has effectively helped to nearly eradicate diphtheria, tuberculosis, smallpox and polio; and

WHEREAS, There is an impending rubella and measles epidemic which may cripple many children; and

WHEREAS, Smoking, use of alcohol and abuse of drugs are recognized as extremely serious problems among our school children; and

WHEREAS, Venereal diseases are prevalent, in many cases because of too little knowledge of cause, prevention and cure—and untreated VD may result in permanent disability and sterility; and

WHEREAS, Herpes is reaching epidemic proportions, and variants of this infection are associated with gynecologic cancer and fetal deaths; and

WHEREAS, Boards of Education are responsible for health education subject matter in the schools, but need medical guidance; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association urge the Ohio Department of Education and Ohio School Boards Association to offer comprehensive health education for all Ohio public school students from kindergarten through the twelfth grade; and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association offer its support to the Ohio Department of Education and the Ohio School Boards Association in organizing the curriculum for this program, and providing to the Ohio Department of Education and the Ohio School Boards Association, upon request, assistance in development of teaching personnel and instruction.

"The Committee is unanimous in recommending that Amended Resolution No. 37-74 be adopted, and, Mr. President, I so move."

By official action, the House **voted to adopt Amended Resolution No. 37-74.**

RESOLUTION NO. 38-74
Welfare Department Payments

"With this resolution, there is an attempt to equate Medicare and Medicaid. This committee feels these two programs cannot be equated. Therefore, Mr. President, I move that Resolution No. 38-74 be not adopted."

By official action, the House **voted that Resolution No. 38-74 be rejected.**

(Continued on Next Page)

RESOLUTION NO. 39-74
National Health Insurance

"The Committee felt that the pertinent point in this resolution was the fact that President Nixon has proposed National Health Insurance that would be subject to review by a PSRO program as a condition of eligibility for payment for services. We feel that PSRO is not a good law. Therefore, we offer the following amended resolution:"

AMENDED RESOLUTION NO. 39-74

WHEREAS, President Nixon's National Health Insurance proposal dispatched to Congress February 7, 1974, would include a provision subjecting medical services to review by the PSRO program as a condition of eligibility for payment under the National Health Insurance Program; THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association instruct its officers and members to work to detach any National Health Insurance Program from the controlling intrusions of existing PSRO laws and regulations or anything similar; and BE IT FURTHER

RESOLVED, To instruct the Ohio delegates to the American Medical Association to present a parallel resolution to the House of Delegates of the American Medical Association for national consideration among the several, component state societies.

"Mr. President, the Committee recommends the acceptance of this amended resolution and I so move."

By official action, the House voted to adopt Amended Resolution No. 39-74.

RESOLUTION NO. 40-74
Common Cause

"The Committee in considering this resolution recognized the fact that the Ohio State Medical Association has been carrying out many of the functions suggested by this resolution. Even though we recognize that the resolution is vague and may need further delineation, we feel that its main content justifies our recommendation that the resolution be amended as follows:"

AMENDED RESOLUTION NO. 40-74

WHEREAS, The physician in private practice is oftentimes also an independent employer and "small businessman" in the marketplace; and

WHEREAS, There is regulation of the physician in this capacity; and

WHEREAS, The employer-physician represents a comparative political minority in the defense of his economic integrity and professional independence; and

WHEREAS, The physician finds himself in common cause with other professional and nonprofessional employers in the independent conduct of his business; NOW, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association continue to seek liaison with other professional and nonprofessional employer groups to seek the mutual advantage of all such politically interested parties; and BE IT FURTHER

RESOLVED, That our delegates to the American Medical Association introduce a similar resolution at the national level.

"Mr. President, I move the adoption of Amended Resolution No. 40-74."

By official action, the House voted to adopt Amended Resolution No. 40-74.

RESOLUTION NO. 41-74
Day of Protest

"The Committee, after careful consideration of public testimony and discussion in closed session, felt that such a 'Day of Protest' might be misconstrued as a strike. We felt that this was not in keeping with our profession and, therefore, the Committee recommends that Resolution No. 41-74 be not adopted. Mr. President, I so move."

By official action, the House voted that Resolution No. 41-74 be rejected.

RESOLUTION NO. 42-74
Let Money Follow People

"The Committee considered all the possible ramifications of this resolution. It was our opinion that carrying out the resolved portions of this resolution might very well destroy the structure of our medical schools in the State of Ohio unless all of the other states agreed to reciprocal expenditures of monies for education. In view of this conclusion, we recommend that Resolution No. 42-74 be not adopted, and, Mr. President, I so move."

By official action, the House voted that Resolution No. 42-74 be rejected.

RESOLUTION NO. 43-74
Sports Medicine Commendation

"We are all cognizant of the work that has been done by the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association and feel that Resolution No. 43-74 is very fitting. Therefore, we heartily recommend the adoption of this resolution, and, noting that the word 'members' should be substituted for the word 'efforts' in the last resolve, Mr. President, I so move."

The resolution reads:

WHEREAS, The Ohio State Medical Association for nearly 14 years has contributed a tremendous amount of time and talent to the betterment of the health and safety of Ohio's young athletes; and

WHEREAS, The vehicle for this effort has been the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association—plus for the past three years the OSMA Section on Sports Medicine; and

WHEREAS, The strong bond of cooperation among the physician members, the Commissioner of the Ohio High School Athletic Association and his staff, and

representatives of the certified athletic training profession in Ohio has resulted in effective, ongoing sports medicine education programs for male and female scholastic coaches, trainers and physical education instructors; and

WHEREAS, Hundreds of Ohio physicians, both M.D. and D.O., who devote countless hours of "leisure" time to serving scholastic athletes and their teams, are offered programs in continuing sports medicine education by both the Joint Advisory Committee and the OSMA Section on Sports Medicine; and

WHEREAS, The leadership and inspiration for the programs of the Joint Advisory Committee and Section on Sports Medicine for the past five years have been provided by its devoted, hard-working chairman; THEREFORE, BE IT

RESOLVED, That the House of Delegates offer its congratulations to the Joint Advisory Committee on Sports Medicine and Section on Sports Medicine for their outstanding programs of continuing education for male and female physicians, coaches, athletic trainers and physical education instructors; and BE IT FURTHER

RESOLVED, That the House of Delegates give a standing ovation to Sol Maggied, M.D., West Jefferson, who is retiring as of this date as Chairman of the Joint Advisory Committee following five years of outstanding service; and BE IT FURTHER

RESOLVED, That copies of this Resolution be distributed to all members of the Joint Advisory Committee on Sports Medicine and to the members of the OSMA Section on Sports Medicine.

By official action, the House **voted to adopt Resolution No. 43-74** and in compliance with the resolution gave a standing ovation to Sol Maggied, M.D., West Jefferson, retiring chairman of the Joint Advisory Committee.

RESOLUTION NO. 44-74
Assignment via "Healthcard"

"The Committee feels that Resolution No. 44-74 is self-explanatory, noting that in the first whereas, a period after 'country' should be inserted and quotation marks inserted with a semicolon after 'any.' With these changes in punctuation, we recommend adoption of this resolution, and, Mr. President, I so move."

With these minor changes the resolution will read:

WHEREAS, President Nixon's presentation to Congress February 7, 1974, included a Comprehensive Health Insurance Plan (CHIP) in which ". . . As part of this program, every American who participates in the program would receive a Healthcard when the plan goes into effect in his state. This card, similar to a credit card, would be honored by hospitals, nursing homes, emergency rooms, doctors, and clinics across the country. Bills for the services paid for with the Healthcard would be sent to the insurance carrier who would reimburse the provider of the care for covered services, then bill the patient for his share, if 'any' "; and

WHEREAS, The Ohio State Medical Association has repeatedly embraced the principle of preserving the physician-patient relationship through the physician's billing the patient directly; and

WHEREAS, The profession's embrace of a "Healthcard" would include embrace of governmental and insurance carrier regulation of the physician-patient relationship with respect to fees, much as physician acceptance of Medicare "assignment" does so now; THEREFORE, BE IT

RESOLVED, The House of Delegates of the Ohio State Medical Association instruct its officers and delegates to the American Medical Association to work at all levels to preserve the right of the physician to bill his patient directly.

By official action, the House **voted to adopt Resolution No. 44-74.**

AMENDED RESOLUTION NO. 45-74
Out-Patient Diagnostic Procedures

"This resolution reiterates what we have asked for many times before. We had testimony by Mr. Vernon Burt, president of Blue Cross of North Eastern Ohio, stating that such contracts are offered on a group and direct-pay basis in North Eastern Ohio. Since such contracts can be written, we feel that Resolution No. 45-74 should be, with the exception of one minor change, adopted. The Amended Resolution No. 45-74 should read as follows:"

WHEREAS, Sound and reasonable Medical Care and greater economy of finances, man-power, and resources would accrue to all; NOW, THEREFORE BE IT

RESOLVED, That all Blue Cross and Blue Shield plans and all voluntary health insurance agencies with the help of the Ohio State Medical Association, Ohio Academy of Family Physicians, and other Medical Societies, develop health insurance policies to cover expenses for OUT-PATIENT DIAGNOSTIC PROCEDURES FOR INDIVIDUALS AS WELL AS GROUPS, which might be carried out either in Hospitals and/or Doctors' offices.

"The Committee recommends the acceptance of this amended resolution and, Mr. President, I so move."

By official action, the House **voted to adopt Amended Resolution No. 45-74.**

RESOLUTION NO. 46-74
Liability Would Shift to the Provider

"After much discussion, the Committee decided that the resolves of this resolution do not offer a solution to the problems set forth in the whereas's. Also, the resolution is written in terminology that was extremely hard to understand. Therefore, Mr. President, we recommend that this resolution be not adopted, and, I so move."

By official action, the House **voted to reject Resolution No. 46-74**

RESOLUTION NO. 47-74
Medical Coupons

"The Committee feels that the intent of this resolution which is to save taxpayers money and eliminate paper work is admirable, but, we feel that such a program cannot be carried out suc-

cessfully. Therefore. we recommend that this resolution be not adopted. and. Mr. President, I so move."

By official action, the House **voted that Resolution No. 47-74 be rejected.**

RESOLUTION NO. 49-74
Constitutional Amendment on Abortion

"This resolution was discussed at length in open hearings and equally as much in our closed session. The consensus of the Committee was that each member of the Ohio State Medical Association should work for or against this proposed constitutional amendment according to the dictates of his own conscience, and that OSMA, as an organization, should not take a stand. Therefore, we recommend, Mr. President, that Resolution No. 49-74 be not adopted and I so move."

By official action. the House **voted to reject the committee's report on Resolution No. 49-74, and to table the Resolution, as originally submitted.**

RESOLUTION NO. 50-74
Bureau of Crippled Children's Services

"This resolution was discussed in detail. Information which had been gathered prior to the meeting was read and discussed. In light of the information that we had available, we felt that a substitute resolution should be written; it is as follows:"

SUBSTITUTE RESOLUTION NO. 50-74

WHEREAS, The Ohio State Medical Association has previously approved and supported the medical care provided under the Bureau of Crippled Children's Services as demonstrated in their awarding of its Distinguished Service Citation to its Medical Director, Dr. Elizabeth Aplin, in 1973; and

WHEREAS, The Committee on Government Medical Care Programs of the Ohio State Medical Association has praised the performance of the Bureau of Crippled Children's Services in past years; and

WHEREAS, The Ohio Department of Public Welfare has replaced the very effective Medical Advisory Committee with a new Consumer/Provider Advisory Committee; and

WHEREAS, The Bureau is no longer in compliance with Federal Regulations that require a Physician Program Director and that this non-compliance threatens to result in a withdrawal of federal funds; NOW, THEREFORE BE IT

RESOLVED, THAT APPROPRIATE PROCEDURES BE INITIATED BY THE COUNCIL, STAFF AND LEGAL COUNSEL TO URGE THE ODPW TO UTILIZE A PRIVATE CARRIER AS AN INTERMEDIARY TO MANAGE THE PAYMENT OF FEES TO THE PROVIDERS OF MEDICAL SERVICES, SUCH AS HAS BEEN PREVIOUSLY RECOMMENDED BY THIS HOUSE REGARDING PAYMENTS OF SERVICE TO WELFARE RECIPIENTS.

"Mr. President. I so move the adoption of this substitute resolution."

By official action, the House **voted to amend Substitute Resolution No. 50-74 as indicated by the additions set forth in capital letters, then adopted it.**

Report on the Minutes of the March 13, 1974, Meeting of the OSMA Judicial and Professional Relations Committee

"The minutes of the March 13, 1974, meeting of the OSMA Judicial and Professional Relations Committee dealt with Resolution No. 3-73, Ethics of Charging Interest Rates, and Resolution No. 30-73, Ethical Status of Provider Agreement. It is the opinion of the Judicial and Professional Relations Committee that the practice of charging rates on overdue accounts by a legend such as, 'Notice: 1% service charge (12%) per annum charged on balance 90 days past due,' and of charging a patient a flat fee on overdue accounts that have been referred to a collection agency are both illegal and unethical.

"After testimony in open session, which included testimony by Dr. George Petznick of the AMA Judicial Council, and discussion by Mr. James Pohlman, OSMA Legal Counsel, we recommend that no action be taken with respect to the report at this time, and that the report be referred back to the Judicial and Professional Relations Committee. This recommendation is based upon the fact, presented through the testimony of both Dr. Petznick and Dr. Richard Meiling, that the AMA Judicial Council has the matter of the ethics of charging interest under active consideration and that the House of Delegates of the AMA at the Annual Meeting next month will probably take action with respect to this issue. The Committee felt it would be unwise under these circumstances for OSMA to adopt a policy position on this issue at this time.

"With respect to the legality of charging interest rates, it was pointed out that by appropriate changes in the accounts rendered by physicians, it would be possible to comply with both the requirements of the federal Truth-In-Lending Act and the state usury laws. Members of the Association who wish to consider this practice are urged to consult with their legal counsel in order to ensure compliance with these laws.

"In reference to Resolution No. 30-73, we are in agreement with the conclusion of the Judicial and Professional Relations Committee (that signing a 'Provider Agreement' with the Ohio Department of Public Welfare is not unethical if an individual physician is so included), and, we recommend that this portion of the report be accepted. Mr. President, I so move."

By official action, the House **voted that the portion of the report dealing with Resolution 3-73, "Ethics of Charging Interest Rates," be re-**

ferred to the Committee on Judicial and Professional Relations, and voted that the portion dealing with Resolution 30-73, "Provider Agreement," be accepted.

"We thank all those who appeared and who gave testimony, and, we thank the OSMA staff for their invaluable help. I personally would like to thank all of the members of this committee: Carl A. Minning, Clermont County; Isador Miller, Champaign County; Paul E. Lyon, Marion County; Alton W. Behm, Geauga County; E. Joel Davis, Stark County; A. John Antalis, Belmont County; John F. Kroner, Jr., Athens County; Chester H. Allen, Scioto County; Henry T. Lapp, Knox County; Jon H. Cooperrider, Ashland County; Roland A. Gandy, Jr., Lucas County, Chairman."

The report of Resolutions Committee No. 3 as a whole, as amended, was approved by the House.

Appreciation Expressed

Dr. Clarke asked Mr. R. Gordon Moore, Mrs. Gail E. Dodson and Mrs. Carol C. Maddy to come forward and he expressed his thanks to them for the execution of their assigned duties during the meeting.

Personal Tribute to Dr. Schultz

Dr. Clarke expressed his personal thanks to Dr. Schultz for his outstanding performance as Councilor, President-Elect, President and Past President.

Inaugural Ceremony

Dr. Schultz administered the presidential oath of office to Dr. James L. Henry and Dr. Clarke, retiring President, presented to Dr. Henry the official gavel and the President's Medallion. Dr. Schultz then presented President's Medallion pins to Dr. and Mrs. Clarke and the certificate of honor to Dr. Clarke. Dr. Henry presented to Dr. Clarke the Past President's Button.

House Complimented

Dr. Richard L. Fulton, Past President of the OSMA and Delegate, Franklin County, asked for the floor and complimented the House of Delegates for the excellent manner in which they conducted the business of the meeting—this being a very difficult year for medicine.

Committees Named

Dr. Henry presented the following committee appointments and they were officially approved by the House of Delegates:

Committee on Education — Dr. John G. Sholl, Cleveland, reappointed chairman for ensuing year; Dr. Howard S. Madigan, Sylvania, reappointed member of the Committee for a term of five years.

Committee on Judicial and Professional Relations — Dr. Homer A. Anderson, Columbus, reappointed chairman for ensuing year; Dr. David A. Barr, Lima, appointed member of the Committee for a term of five years.

Committee on Membership and Planning — Dr. William R. Schultz, Wooster, appointed chairman for ensuing year; Dr. William M. Wells, Newark, reappointed for a term of five years.

Committee on Public Relations — Dr. Luther W. High, Millersburg, reappointed chairman for ensuing year; Dr. Peter A. Overstreet, Toledo, reappointed for a term of five years.

Committee on Scientific Work — Dr. Jack E. Tetirick, Columbus, reappointed chairman for ensuing year; Dr. Robert G. Page, Toledo, reappointed member of the Committee for a term of five years; Dr. Robert S. Young, Johnstown, reappointed member of the Committee for a term of five years.

There being no further business, the House of Delegates then adjourned sine die.

ATTEST: Hart F. Page
Executive Director

ATTENDANCE OF DELEGATES
OSMA House of Delegates
1974 ANNUAL MEETING

County	Delegate	First Session	Final Session
	FIRST DISTRICT		
ADAMS	William J. Lundy	x	
	Bruce Ashley		x
BROWN	John R. Donohoo	x	
BUTLER	Joseph H. Brandabur	x	
	Jerry D. Hammond	x	x
	James F. Stewart	x	x
	James M. Smith		x
CLERMONT	Carl A. Minning	x	x
CLINTON	Foster K. Boyd		x
HAMILTON	John E. Albers	x	x
	Frederick Brockmeier	x	
	Eugene J. Burns	x	x
	Stewart B. Dunsker		x
	Charles D. Feuss, Jr.	x	x
	Harry H. Fox	x	x
	Robert S. Heidt	x	x
	Harry K. Hines	x	x
	James L. Leonard	x	x
	Glenn Overley	x	x
	Glenn W. Pfister	x	x
	William J. Schrimpf	x	x
	Calvin F. Warner	x	x
	Andrew J. Weiss	x	x
HIGHLAND	Glenn B. Doan	x	x
WARREN	Thomas E. Fox	x	x
	SECOND DISTRICT		
CHAMPAIGN	Isador Miller	x	x
CLARK	Ernest H. Winterhoff	x	x
	Henry A. Diederichs		x
DARKE	Jesse L. Heise	x	
GREENE			
MIAMI	A. Robert Davies	x	x
MONTGOMERY	Robert K. Finley, Jr.	x	x
	Konrad A. Kircher	x	x
	W. J. Lewis	x	x
	Theodore L. Light	x	x
	George L. Parkin	x	x
	Frederic C. Schnebly	x	x
PREBLE			
SHELBY			
	THIRD DISTRICT		
ALLEN	David A. Barr	x	
	William T. Collins		x
	Robert L. Holladay	x	x
AUGLAIZE	Elizabeth Y. Kuffner	x	x
CRAWFORD	Johnson H. Chow	x	x
HANCOCK	Chester L. Samuelson	x	x
HARDIN	Robert B. Elliott	x	x
LOGAN	James H. Steiner	x	x
MARION	Paul E. Lyon	x	x
MERCER	James J. Otis	x	x
SENECA	Walter A. Daniel	x	x
VAN WERT	Alford C. Diller	x	x
WYANDOT			
	FOURTH DISTRICT		
DEFIANCE	Paul E. Brose	x	
FULTON			
HENRY	Thomas F. Moriarty	x	x
LUCAS	C. Douglass Ford	x	x
	Roland A. Gandy, Jr.	x	x
	B. Leslie Huffman, Jr.	x	x
	M. Brodie James	x	x
	Thomas J. O'Grady	x	
	Peter A. Overstreet	x	x
	Richard J. Wiseley		x
OTTAWA	John F. Bodie	x	x
PAULDING			
PUTNAM	James B. Overmier	x	x
SANDUSKY	Willis L. Damschroder	x	x
WILLIAMS	Robert W. Dilworth		x
WOOD	William H. Roberts	x	x
	FIFTH DISTRICT		
ASHTABULA	Samuel L. Altier	x	x
CUYAHOGA	Felino V. Barnes	x	
	Matthew R. Biscotti	x	x
	William F. Boukalik	x	x
	John H. Budd	x	x
	Theodore J. Castele	x	x
	C. A. Colombi	x	x
	Henry A. Crawford	x	x
	Nicholas G. De Piero	x	x
	Clarence L. Huggins		x
	Roscoe J. Kennedy	x	x
	Edward F. Kieger, II	x	x
	John A. Kmieck	x	x
	Vincent T. LaMaida	x	x
	Leonard L. Lovshin	x	x
	Hermann Menges, Jr.	x	x
	James R. O'Malley	x	x
	George W. Petznick	x	x
	P. John Robechek	x	x
	John H. Sanders	x	x
	A. B. Schneider	x	x
	Howard S. Siegel	x	x
	Frederick T. Suppes	x	x
	William V. Trowbridge		x
	Warner W. Tuckerman	x	
	H. S. Van Ordstrand	x	x
GEAUGA	Alton W. Behm	x	x
LAKE	Edward D. Hudgens	x	x
	Carl G. Madsen, Jr.	x	x

County	Delegate	First Session	Final Session
	SIXTH DISTRICT		
COLUMBIANA	William S. Banfield	x	x
MAHONING	J. James Anderson	x	x
	John C. Melnick	x	x
	C. Edward Pichette	x	x
	Jack Schreiber	x	x
PORTAGE	F. Michael Sheehan	x	
	John F. Fulton		x
STARK	E. Joel Davis	x	x
	Frank O. Goodnough	x	x
	Edward E. Grable	x	x
	William H. White, Jr.	x	x
SUMMIT	Rocco M. Antenucci	x	x
	Robert R. Clark	x	x
	William Dorner, Jr.	x	x
	John A. Karnoupakis	x	x
	W. Paul Kilway, Jr.	x	x
	Emmett P. Monroe	x	x
	Marshall R. Werner	x	x
TRUMBULL	Joseph L. Logan		x
	George Mokris	x	
	Robert J. Paul	x	
	SEVENTH DISTRICT		
BELMONT			
CARROLL	Carl A. Lincke	x	
	Thomas J. Atchison		x
COSHOCTON	Norman L. Wright	x	
HARRISON	Elias Freeman	x	x
JEFFERSON	Sanford Press	x	
	James V. Current		x
MONROE			
TUSCARAWAS	H. Judson Reamy	x	
	Philip T. Doughten		x
	EIGHTH DISTRICT		
ATHENS	John F. Kroner, Jr.	x	
FAIRFIELD	Donald B. Nichols	x	
	James A. Merk		x
GUERNSEY	Robert A. Ringer	x	x
LICKING	Frederick N. Karaffa	x	x
MORGAN			
MUSKINGUM	W. B. Devine	x	x
NOBLE			
PERRY			
WASHINGTON	Gregory B. Krivchenia	x	x
	NINTH DISTRICT		
GALLIA	Thomas P. Price, Jr.	x	x
HOCKING	L. W. Starr	x	x
JACKSON	Garrett B. Ackerman	x	x
LAWRENCE	A. Burton Payne	x	x
MEIGS	Roger P. Daniels	x	x
PIKE			
SCIOTO	Chester H. Allen	x	x
VINTON			

County	Delegate	First Session	Final Session
	TENTH DISTRICT		
DELAWARE	Adelbert R. Callander	x	
	Robert S. Caulkins, Jr.		x
FAYETTE	Byers W. Shaw	x	
FRANKLIN	Homer A. Anderson	x	x
	Robert C. Atkinson	x	x
	James E. Barnes	x	x
	Joseph A. Bonta	x	x
	Keith DeVoe, Jr.	x	x
	Richard L. Fulton	x	x
	John N. Meagher		x
	H. William Porterfield	x	x
	Jack E. Tetirick	x	
	James Hutchison Williams		x
KNOX	Henry T. Lapp	x	x
MADISON	Sol Maggied	x	
MORROW	David James Hickson	x	x
PICKAWAY	Ray Carroll	x	
	Robert G. Smith		x
ROSS	Joseph McKell	x	x
UNION			
	ELEVENTH DISTRICT		
ASHLAND	Jon H. Cooperrider	x	x
ERIE	S. Baird Pfahl, Jr.	x	x
HOLMES	Luther W. High	x	x
HURON	Nino M. Camardese	x	x
LORAIN	Charles G. Adams	x	x
	Delbert L. Fischer	x	x
	Harold E. McDonald	x	x
MEDINA	Richard W. Avery	x	x
RICHLAND	Harold F. Mills	x	x
	James W. Wiggin	x	x
WAYNE	A. Burney Huff	x	x

	OFFICERS (Members of The Council)		
President	Oscar W. Clarke	x	x
President-Elect	James L. Henry	x	x
Past President	William R. Schultz	x	x
Secretary-Treasurer	William M. Wells	x	x
First District	Stephen P. Hogg	x	x
Second	James G. Tye	x	x
Third	John C. Smithson	x	x
Fourth	George N. Bates	x	x
Fifth	John J. Gaughan	x	x
Sixth	Maurice F. Lieber	x	x
Seventh	Robert E. Rinderknecht	x	x
Eighth	Richard E. Hartle	x	x
Ninth	Thomas W. Morgan	x	x
Tenth	James C. McLarnan	x	x
Eleventh	Robert G. Thomas	x	x
	TOTAL	158	154



To

JOHN H. BUDD, M.D.

the

OHIO STATE MEDICAL ASSOCIATION

PROUDLY AWARDS

this

CITATION FOR DISTINGUISHED SERVICE TO MEDICINE

Fellow Members of the House of Delegates:

It seems somewhat understated to give John Budd just one Ohio State Medical Association Distinguished Service Citation. Your OSMA Council voted unanimously and enthusiastically to honor this distinguished physician and medical leader, just as his own Academy of Medicine of Greater Cleveland honored him in 1973 with its coveted Distinguished Member award. Our difficulty arose in determining for which of John Budd's outstanding contributions to medicine this Citation should be given.

He richly merits such recognition for his outstanding contributions as a member of this House of Delegates. Further, he was chairman of its special Ad Hoc Committee to Study Ohio Medical Indemnity (1963-64). He also served for ten years on our Committee on Public Relations and Economics. He always has been a willing worker who accepts without hesitation all the demands we have placed on his time and his great abilities.

On the other hand, John should have this award for his significant leadership as Chairman of OSMA's delegation to the American Medical Association. In that House of Delegates, John soon gained the high regard, warm friendships and admiration of physicians throughout the United States. They quickly recognized, as we did in Ohio, his dedication, insight, and compassion for the profession he loves.

Should this Citation be given to John Budd, Citizen? Born in New Brunswick, Canada, and a graduate of Dalhousie University Medical School in Halifax, Nova Scotia, John's contributions as a citizen of and his love for his adopted country and his community serve as a goal to be sought by all physicians.

Why not give John Budd this Citation for his work as a member of the American Medical Association Board of Trustees and as AMA Secretary-Treasurer? After all, that is hard, grueling, time-devouring, demanding service that benefits all physicians and their patients. The measure of John's abilities at the Board of Trustees level is found in his unanimous re-election to the Board by the AMA House of Delegates in 1973.

We thought about giving this Citation to Dr. Budd for being, all at the same time, a compassionate family physician, an accomplished musician, a sports enthusiast of great scope, and an unceasing friend.

And so, to present this award in the most comprehensive scope, we concluded that the best method is as follows:

The Ohio State Medical Association, in this House of Delegates
assembled in Cleveland, Ohio herewith proudly and gratefully presents this
Distinguished Service Citation to John H. Budd, Doctor of Medicine, just for being
John Budd
May 12, 1974

William M. Wells, M.D.
Secretary-Treasurer

Oscar W. Clarke, M.D.
President

Proceedings of The Council

Meeting of May 16, 1974

THE COUNCIL of the Ohio State Medical Association met May 16, 1974 in Cleveland, Ohio. All members of the Council were present. In addition, the following attended the meeting: Messrs. Hart F. Page, Charles W. Edgar, Jerry J. Campbell, Robert D. Clinger, David L. Rader, Douglas R. Houser, Mrs. Katherine E. Wisse, Mr. R. Gordon Moore, and Mrs. Gail E. Dodson. Also attending were James E. Pohlman, Esq., Columbus, OSMA's legal counsel, and Mr. Guy D. Beaumont, Jr., representing the American Medical Association Field Service.

Dr. Henry called the meeting to order and introduced Dr. C. Edward Pichette, new Councilor from District Six.

Ratification of Appointments to Special Committees

Dr. Henry presented to the Council his appointments to special committees for 1974-75. The appointments were duly ratified by the Council.

Federal Legislative Liaison Committee

By official action of the Council, the Committee on Legislation was designated as the Federal Legislative Liaison Committee. Mr. Charles W. Edgar will serve as its Secretary. By official action the Council established the Committee on State Legislation, with the members to be selected by the President. Mr. David L. Rader will serve as its Secretary.

Washington Visitation

The Council selected June 11, 1974 as the date for the Washington Visitation, with arrival in Washington scheduled for June 10. The Council suggested certain written materials be available to the Congressmen during the visit.

Constitution and Bylaws Committee

The President asked for suggestions from the Council for appointment to the Constitution and Bylaws Committee which will also serve as a Committee on Professionalism, both of which were established by action of the 1974 House of Delegates.

American Medical Association

By official action, the Council voted to rescind a Resolution on credentialing of medical devices which had been submitted for consideration at the June meeting of the AMA. The withdrawal of the Resolution was at the suggestion of the Ohio AMA's delegation.

The Council voted to submit to the June meeting of the AMA a Resolution to make it possible for members to receive the "green sheet" in lieu of another publication of the AMA.

Resolutions of Appreciation

On motion of Dr. Clarke, duly seconded, the Council adopted the following Resolutions:

1. A statement of appreciation to the staff of the Ohio State Medical Association for their dedication to the success of the Annual Meeting.
2. An expression of appreciation to the Cleveland Academy of Medicine for its cooperation and assistance with the Annual Meeting, including its participation in the physicians' art exhibit project.
3. A statement of appreciation to the Cleveland Chapter of the American Red Cross for establishing and staffing an emergency aid station at the meeting.
4. An expression of appreciation to the Chief of Staff of St. Vincent's Charity Hospital for providing medical emergency services at that institution.

The President announced the Council would meet again July 27-28, 1974 in Columbus. A joint meeting of the Auditing and Appropriations Committee and the Membership and Planning Committee was announced for June 29-30, 1974 in Columbus.

ATTEST: Hart F. Page
Executive Director

Annual Meeting Attendance

ATTENDANCE AT THE 1974 OSMA Annual Meeting showed member physicians in attendance from 79 of Ohio's 88 counties. In all, 1048 member of the Association were present. In addition, 101 guest physicians and 26 medical students were in attendance, making a total of 1175 physicians and future physicians present. Persons registered as scientific, health education and technical exhibitors numbered 405. Also present were 1010 persons registered as members of the Woman's Auxiliary, nurses, technicians, other professional personnel and miscellaneous guests. The total attendance was 2590.

Following are tabulated figures on Annual Meeting attendance.

1974 Annual Meeting Registration by Counties

With OSMA Membership Data

County	MEMBERSHIP Dec. 31 1973	MEMBERSHIP May 9 1974	Annual Mtg. Registration
Adams	13	12	2
Allen	140	133	13
Ashland	30	27	2
Ashtabula	56	60	5
Athens	38	40	2
Auglaize	20	15	2
Belmont	58	59	6
Brown	17	18	1
Butler	209	201	4
Carroll	9	9	4
Champaign	14	14	2
Clark	141	140	8
Clermont	20	20	4
Clinton	20	22	1
Columbiana	81	73	6
Coshocton	20	20	3
Crawford	37	33	4
Cuyahoga	2,335	2,145	424
Darke	26	26	4
Defiance	28	27	4
Delaware	27	27	3
Erie	67	68	6
Fairfield	49	50	7
Fayette	13	13	1
Franklin	1,006	768	87
Fulton	17	16	1
Gallia	33	31	4
Geauga	31	30	9
Greene	55	55	1
Guernsey	27	21	2
Hamilton	1,306	1,245	47
Hancock	42	43	3
Hardin	23	19	2
Harrison	9	9	2
Henry	12	10	2
Highland	17	12	2
Hocking	8	8	1
Holmes	9	9	5
Huron	32	32	6
Jackson	12	7	2
Jefferson	77	78	5
Knox	33	38	8
Lake	123	129	26
Lawrence	26	23	2
Licking	77	72	9
Logan	15	17	1
Lorain	227	218	30
Lucas	636	600	39
Madison	17	16	2
Mahoning	354	339	21
Marion	80	74	4
Medina	60	50	7
Meigs	4	4	1
Mercer	18	18	2
Miami	67	59	5
Monroe	3	8	1
Montgomery	672	664	21
Morgan	4	4	—
Morrow	7	7	1
Muskingum	79	81	8
Noble	2	2	—
Ottawa	23	24	2
Paulding	7	8	1
Perry	8	9	—
Pickaway	20	22	2
Pike	12	12	—
Portage	59	58	11
Preble	6	7	—
Putnam	10	7	2
Richland	132	125	12
Ross	45	47	6
Sandusky	46	49	3
Scioto	67	62	2
Seneca	37	38	6
Shelby	19	20	—
Stark	372	354	31
Summit	602	616	39
Trumbull	151	141	11
Tuscarawas	51	52	6
Union	17	17	—
Van Wert	19	18	3
Vinton	2	—	—
Warren	15	13	3
Washington	35	33	7
Wayne	63	62	10
Williams	21	20	1
Wood	42	41	3
Wyandot	10	8	—
Honorary	5	5	—
TOTAL	10,584	9,936	1,048

OSMA Annual Meeting Registration — 1919 to 1974

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux.: Mis. Guests	Sc. and Tech. Exhibitors	Total
1919	Columbus	1173			264	92	1539
1920	Toledo	860			105	80	1062
1921	Columbus	1275			104	96	1503
1922	Cincinnati	1066			184	70	1341
1923	Dayton	1117			202	76	1414
1924	Cleveland	1301			180	109	1603
1925	Columbus	1204			361	107	1689
1926	Toledo	903			120	83	1125
1927	Columbus	1320			286	82	1705
1928	Cincinnati	916			92	80	1115
1929	Cleveland	1231			249	124	1619
1930	Columbus	1241			435	86	1775
1931	Toledo	826			198	50	1087
1932	Dayton	978			201	45	1226
1933	Akron	858			160	25	1049
1934	Columbus	1069			410	51	1539
1935	Cincinnati	973			197	84	1271
1936	Cleveland	1099			563	137	1818
1937	Dayton	1103			366	64	1551
1938	Columbus	1330			619	104	2068
1939	Toledo	1056			271	84	1426
1940	Cincinnati	1126			323	114	1589
1941	Cleveland—Joint Meeting with AMA						
1942	Columbus	1221			527	119	1880
1943	Columbus	544			160		717
1944	Columbus	830			411	130	1421
1945	No Meeting						
1946	Columbus	1262	130	65	507	157	2121
1947	Cleveland	1502	158	15	411	328	2414
1948	Cincinnati	1362	293	27	491	214	2387
1949	Columbus	1533	162	221	462	230	2608
1950	Cleveland	1587	260	102	707	376	3032
1951	Cincinnati	1208	162	185	647	352	2554
1952	Cleveland	1366	204	49	687	395	2701
1953	Cincinnati	1155	180	224	578	298	2435
1954	Columbus	1222	197	173	701	252	2545
1955	Cincinnati	1360	211	185	738	317	2810
1956	Cleveland	1601	338	120	1029	489	3577
1957	Columbus	1164	149	320	689	368	2690
1958	Cincinnati	1327	164	45	674	325	2535
1959	Columbus	1359	293	445	721	364	3182
1960	Cleveland	1642	489	48	1026	447	3652
1961	Cincinnati	1256	231	24	751	301	2563
1962	Columbus	1304	265	343	736	371	3019
1963	Cleveland	1502	336	19	893	441	3191
1964	Columbus	1428	332	297	1002	376	3435
1965	Columbus	1330	275	335	968	394	3302
1966	Cleveland	1484	309	22	865	355	3035
1967	Columbus	1327	286	394	1178	405	3590
1968	Cincinnati	1300	230	35	1287	613	3465
1969	Columbus	1344	219	208	1780	518	4069
1970	Columbus	1160	189	224	1355	477	3405
1971	Columbus	1049	159	182	1116	451	2957
1972	Cincinnati	1118	204	37	1172	498	3029
1973	Columbus	1100	130	93	1260	431	3014
1974	Cleveland	1048	101	26	1010	405	2590

Woman's Auxiliary Report...

Address Presented Before the OSMA House of Delegates at the 1974 Annual Meeting in Cleveland

By Mrs. Karl Uligny
1973-1974 President, Woman's Auxiliary to the OSMA

WE IN OHIO are very proud of Mrs. William Myers, one of our Auxilians who served on the Governor's Health Care Task Force. This Task Force would develop an extensive and up-to-date information base on Ohio Health Care. It was the duty of the Task Force to recommend whatever changes, programs or new directives might be necessary to improve the delivery of health care to Ohio citizens.

Mrs. Myers submitted a minority report, giving her views on the work of the committee which the Council of the Ohio State Medical Association voted to approve and support. She also sent a letter to the Governor which The Council endorsed.

Mrs. Myers concluded that Ohio has an adequate number of physicians but distribution of physicians is the problem. She also concluded that no patient was turned away because of lack of funds. We, your wives, know how dedicated you are to your profession and that patients do receive quality care regardless of their financial status.

Four Regional Workshops were held this year to inform all Auxilians of the work we are doing and how they can help in promoting good public relations. Although the total attendance was not much larger than in previous years, we reached Auxilians that had never attended a workshop in the past.

We have a membership this year of 5,068. These members gave a total of $84,604.47 to AMA-ERF to date and are hoping to go over the $90,000 mark.

Through Health Manpower, $7,050 was offered in loans by the county auxiliaries and $35,251.02 was given in scholarships to help young people enter medicine or one of its allied professions.

A total of $11,635 was donated to Project Hope, and over 30,000 pounds of drugs and other supplies were sent overseas through our International Health Program to further good international relations.

Legislation continued to be one of our major priorities. There was a day at the legislature where each of us met with our respective representatives. Many counties held "at home parties" and promoted voter registration. Through "Legsline" we wrote to our legislators concerning the Chiropractic Licensing Bill and held two letter writing campaigns on HMO Senate 14 and Phase IV economic wage and price controls.

To carry out Health Education, a number of counties had mental health programs. Hamilton County has established a Center for Early Detection of Breast Cancer where a minimum of 5,000 women between the ages of 35 and 75 are being screened annually. Montgomery County established an Ostomy Club for children up to the ages of 18, a program which has proven to be very successful.

A Conference on Child Abuse-Neglect was held in Columbus, in conjunction with the State Department of Public Welfare. Its purpose was to sensitize interested citizens to the severity of these problems and to stimulate community concern and action. Your President, Dr. Oscar Clarke, was the "keynote" speaker for this conference and without his interest and concern the program would not have gotten off the ground.

Cuyahoga County has been working with the local welfare department for the past two years on a pilot program concerning Child Abuse which has been very successful and is a continuing program.

There is one WA-SAMA Chapter in Ohio which is at the Ohio State University Medical School. The Franklin County Auxiliary has been most generous in donating to this Chapter by giving them $150.00 to carry on some of their work.

The Women's Auxiliary is very proud of Ohio's physicians and the fine work they are doing.

Our New Address



The Ohio State Medical Association

and

The Ohio State Medical Journal

600 South High Street

Columbus, Ohio 43215

Obituaries

Vladas Adams, M.D., Akron; medical degree from University at Tubingen, Germany, 1949; aged 52; died April 23; member OSMA and AMA.

Brinton J. Allison, M.D., Jackson; Ohio State University College of Medicine, 1929; aged 74; died May 7; member of OSMA and AMA.

Richard Frank Baer, M.D., Toledo; Ohio State University College of Medicine, 1952; aged 50; died May 12; member of OSMA and AMA.

David Allan Belinkey, M.D., Youngstown; Temple University School of Medicine, 1927; aged 71; died May 28; member of OSMA and AMA.

Richard Michael Brady, M.D., Akron; St. Louis University School of Medicine, 1934; aged 66; died April 29; member of OSMA and AMA.

Ernest Joseph Burrows, M.D., Cuyahoga Falls; St. Louis University School of Medicine, 1935; aged 67; died May 6; member of OSMA and AMA.

Andrew Samuel Burton, M.D., Newark; Meharry Medical College School of Medicine, 1928; aged 80; died May 20; member of OSMA and AMA.

Arthur L. Dobosiewicz, M.D., New Lexington; Medical Degree from the University of Belgrade, 1933; aged 75; died April 24; member of OSMA and AMA.

Lloyd Sanderson Early, M.D., Columbus; Western Reserve University School of Medicine, 1925; aged 78; died May 13; member of OSMA and AMA.

Paul Parkhurst Gintzel, M.D., Toledo; Toledo Medical College, 1910; aged 88; died April 20; former member of OSMA.

Forest Charles Hunter, M.D., Lima; Ohio State University College of Medicine, 1938; aged 64; died May 8; member of OSMA and AMA.

Elizabeth M. Martin, M.D., Wooster; University of Wisconsin Medical School, 1956; aged 61; died April 29; member of OSMA and former member of AMA.

Hippolit Matuzeski, M.D., Cleveland and Lakewood; Western Reserve University School of Medicine, 1924; aged 81; died May 14; member of OSMA and AMA.

Raymond Charles Mauger, M.D., Newark; Ohio State University College of Medicine, 1914; aged 82; died May 8; former member of OSMA.

John Ralph Shoemaker, M.D., Cuyahoga Falls; Ohio State University College of Homeopathic Medicine, 1916; aged 81; died May 5; member of OSMA and AMA.

Paul Joseph Sindelar, M.D., Cleveland; St. Louis University School of Medicine, 1955; aged 44; died May 7; member of OSMA and AMA.

Dean Earl Stillson, M.D., Youngstown; Western Reserve University School of Medicine, 1943; aged 55; died April 21; member of OSMA and AMA.

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References: 1. Modell, W., ed.: Drugs of Choice 1970-1971, St. Louis, The C. V. Mosby Company, 1970, p. 196. **2.** Goodman, L. S., and Gilman, A., ed.: The Pharmacologic Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 327. **3.** Maslansky, L.: Paper delivered at Fourth International Congress of Allergology, New York, Oct. 18, 1961 abstracted Excerpta Med. Internat. Congress Series, No. 42, p. 124.

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Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

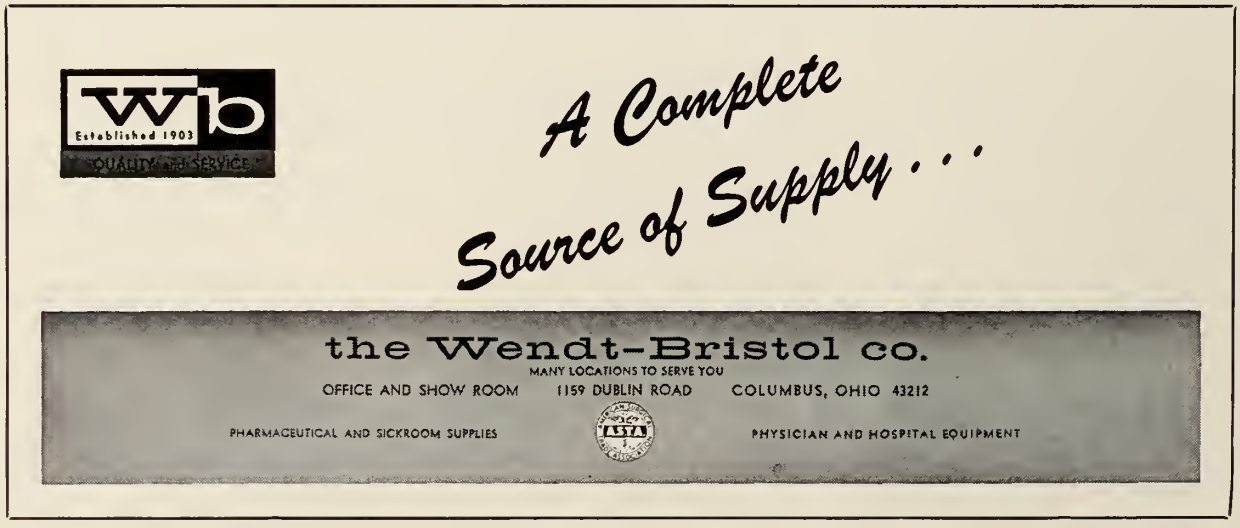
THE WORD LEAPED OUT in bold letters from the cover of the convention program—YOU. And YOU meant every auxiliary member in the State of Ohio. Mrs. Karl Ulicny, 1973-74 president, had chosen as her convention theme "The Focus Is on You" and indeed it was. There was participation and there was learning and there was communication in the broadest sense. And there was fun. All this, of course, took place in Cleveland at the organization's 34th annual meeting May 12 through May 15 at the Cleveland Plaza Hotel. Mrs. Thomas L. Manning and Mrs. F. M. Freimann served as convention chairmen and there just aren't enough words of praise to heap on them for the terrific job they did. Nor could I omit mention of their hard-working and marvelously productive committees!

Activities started on Monday, May 12, with the preconvention Board meeting in the morning, an extra-special Board luncheon at noon and then the outstanding Mini-Conference of the afternoon for county presidents and presidents-elect. This was emceed by Mrs. S. J. Glueck, state president-elect. The Mini-Conference was quite a "production"; it certainly produced a most helpful, meaningful and interesting session that was very well received. At 6:00 P.M., Dr. and Mrs. Ulicny hosted a reception in their suite which was followed by the State Board and Gavel Club dinner to which the doctor-husbands were invited.

At the opening business session on Tuesday morning, May 13, Mayor Ralph J. Perk, of Cleveland, welcomed the auxiliary to the city. Dr. Oscar Clarke, 1973-74 OSMA President, addressed the House of Delegates and extended thanks for the group's continuing important role and help on behalf of medicine. The keynote speech on "Volunteerism" was given by Mrs. Theodore Wedel of Washington, D.C., national chairman of volunteers of the American Red Cross and a prominent lecturer. Also presented that morning was Mrs. Ulicny's report on her year of auxiliary stewardship. *The Journal* has detailed that report on page 466.

Another speaker was the National Auxiliary representative, Mrs. Max E. Olsen, of Iowa. Her talk covered the A to Z of auxiliary and she really didn't miss one letter of the alphabet! The report of the Resolutions Committee was presented by Mrs. Carl F. Goll, Jefferson County, chairman. Two resolutions were introduced, calling for state honorary memberships for Mrs. Christopher Colombi, of Cuyahoga, and Mrs. Samuel L. Meltzer, of Scioto, both past state presidents. The House of Delegates voted that both such honorary memberships be conferred.

Mrs. Louis Loria, nominating committee chairman, presented the nominative slate, following which the delegates voted unanimously on its acceptance. The 1974-75 officers and directors in-



clude: Mrs. S. J. Glueck of Clark, president; Mrs. Robert Krone, Hamilton, president-elect; Mrs. William Myers, Pickaway, first vice-president; Mrs. Albert May, Marion, second vice-president; Mrs. S. Baird Pfahl, Erie, third vice-president; Mrs. Herman Lubens, Montgomery, corresponding secretary; Mrs. Paul Chrenka, Cuyahoga, recording secretary; Mrs. W. L. Damschroder, Sandusky, treasurer; directors-at-large: Mrs. Kenneth Smith, Miami; Mrs. David Smith, Delaware; and Mrs. Robert Holladay, Allen. District directors: second, Mrs. Donald Buck, Montgomery; fourth, Mrs. Burton Nelson, Lucas; sixth, Mrs. Karl Wieneke, Mahoning; eighth, Mrs. Fred Karaffe, Licking; and tenth, Mrs. Paul Metzger, Franklin. Elections were held Tuesday afternoon for the 1974-75 Nominating Committee and for delegates to the 1974 National Convention.

Following the moving, traditional In Memoriam Service by Mrs. Emil Barrows, Hamilton, the first business session adjourned. The afternoon's special treat was a tour of University Circle and a tea at the beautiful Garden Center. Mrs. Ulicny and Mrs. Glueck entertained the 1973-74 county presidents and presidents-elect at a late afternoon reception. Board members were also invited.

The President's Breakfast at 7:30 A.M. Wednesday morning featured "That County Special"—a simulated television panel show in which 24 county presidents participated. (There were the tv camera, the monitor and very special commercials!) Also presented at the Breakfast was the report of Dr. William Porterfield, OMPAC chairman, who gave an up-to-date "sketch" of the OMPAC picture.

Three counties were the recipients of special AMA-ERF awards: Mrs. Henry Holden, Mahoning, state chairman, presented certificates to **Hamilton** for the largest amount; **Cuyahoga** for the biggest increase over last year; and **Belmont** for the largest per capita. And not so incidentally, Ohio is sending close to $90,000.00 to AMA-ERF for this auxiliary year! Very, very nice going, to state it very, very mildly!! Congratulations, Velma.

The second business session convened at 9:30 A.M., presided over by Mrs. Ulicny. Dr. James L. Henry, incoming OSMA president, addressed the House of Delegates with a "Challenge from OSMA." Mrs. Max Olsen, the national representative, conducted the installation ceremony for the new officers and directors. Mrs. Louis Loria, Trumbull, presented the state past president's pin to Mrs. Ulicny and Mrs. Ulicny in turn presented the president's pin and gavel to Mrs. Glueck.

In her inaugural address, Mrs. Glueck's emphasis was on her theme—HELPING HANDS—with special priority in the area of health education. "The time has come," she said, "for acting on the problem of getting a total health education curriculum, K-12, into every school system in Ohio . . . we have been blind to our greatest and most important natural resource, our children . . . this is also going to be the year of the 'Big C'—let us **contemplate** the tasks ahead, **create** new ideas, **correlate** on-going programs, **cooperate** within our organization and **communicate** with each other and outside agencies." The auxiliary's new president ended her talk with a poem that began "Tis the human touch in this world that counts, The touch of your hand and mine . . . ." And when she had finished, she asked her audience not to applaud but rather to turn, each to the other, and shake hands.

Because of space restrictions, it has been impossible to give the whole convention story. Hopefully, though, this bird's-eye-view will at least highlight the reality and the promise of auxiliary activity. Three last words—Cabaret Playhouse—beautiful!



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U.S. Adds 9,845 Physicians AMA Center Reports

There were 9,845 more physicians in the United States at the end of 1973 than in the previous year, according to the American Medical Association's Center for Health Services Research and Development.

The final figure in the AMA master file of physicians at the end of the year was 366,379, compared with 356,534 at the end of 1972.

The number of physicians providing patient care rose from 292,210 in 1972 to 295,257 last year. Those listing their major activity as medical teaching rose from 5,636 in 1972 to 6,183 last year; the number in research dropped from 9,290 to 8,332.

The number of general practitioners decreased from 55,348 in 1972 to 53,946 last year. Physicians in medical specialties rose to 86,924 last year from 84,153 a year earlier; those in surgical specialties rose to 91,549 from 91,058.

Group Insurance Administrator Opens Cleveland Office

The Ohio State Medical Association group insurance administrator, Turner & Shepard, Inc., has opened a Cleveland office to serve members in the area, it was announced by Jack Hesler, president of Turner and Shepard.

Clifford E. Mosher was named account executive for the northeast area of the state.

The new office is part of Turner and Shepard's continued statewide expansion to better serve professional group members.

The Cleveland office address is Turner and Shepard, Inc., Suite 228, 1900 Euclid Avenue, Cleveland, Ohio 44115.

For a listing of available cassette tapes in the field of orthopaedic surgery, physicians may write to Orthopaedic Audio-Synopsis Foundation, 1510 Oxley St., South Pasadena, Calif. 91030.

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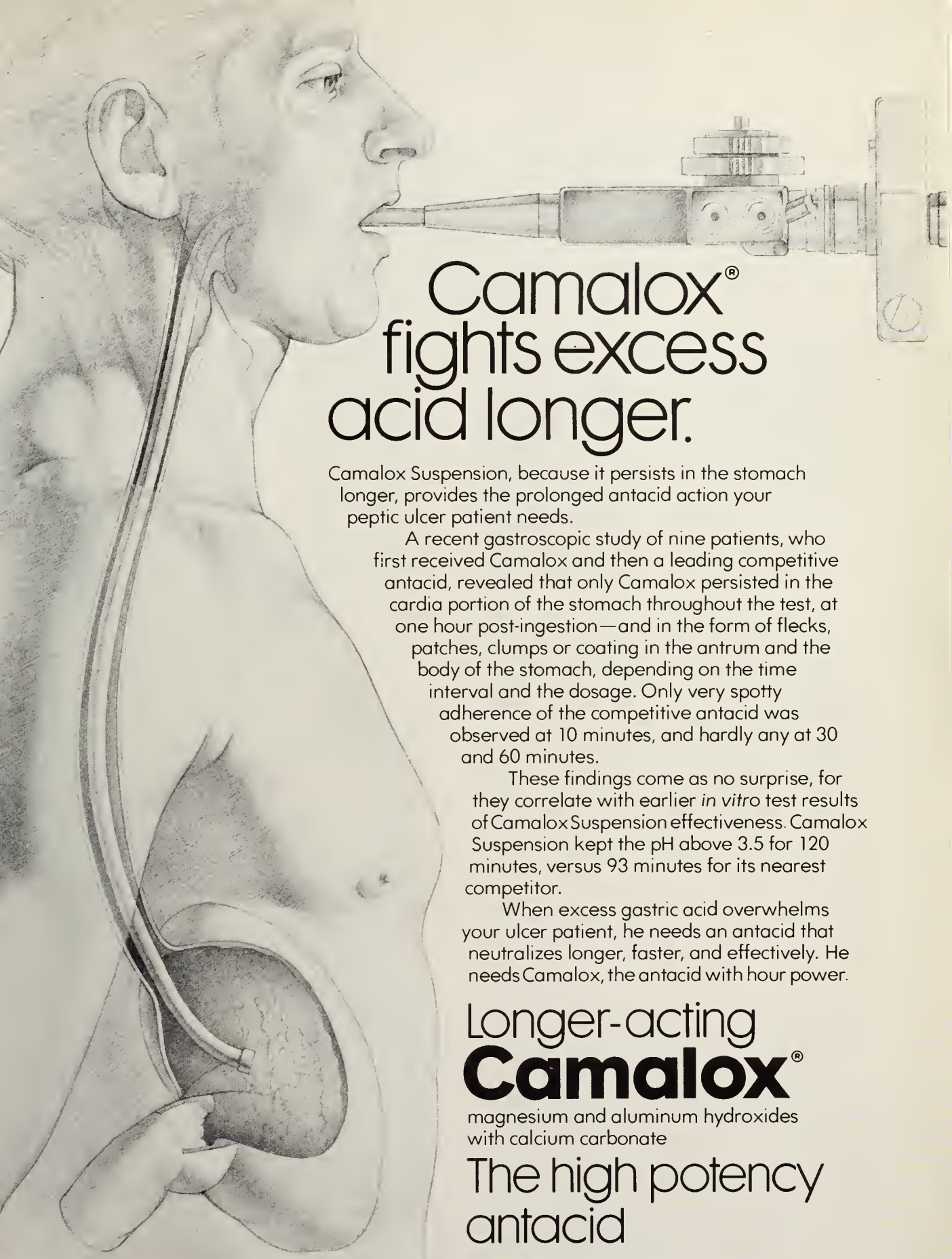
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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964



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County Societies' Officers and Meeting Dates

ROSTER UPDATED THROUGH JUNE 15, 1974

First District

Councilor: Stephen P. Hogg, Cincinnati 45219
250 Wm. Howard Taft Rd.

ADAMS—Kenneth C. Jee, President, West St., Winchester 45697; Hazel L. Sproull, Secretary, 113 East Mulberry St., West Union 45693; 2nd Tuesday of Jan., Apr., July, and Oct.

BROWN—Kevin C. McGann, President, 121 N. Main St., Georgetown 45121; Antonio P. Mendoza, Secretary, 120 E. Plane St., Bethel 45106; 1st Sunday.

BUTLER—Wm. Thomas Scott, President, 701 N. University Blvd., Middletown 45042; Mr. E. Clifford Roberts, Executive Secretary, 111 Buckeye St., Hamilton 45011; 4th Wednesday.

CLERMONT—William B. Selnick, President, Second and East Loveland Ave., Loveland 45140; V. P. Mathew, Secretary, 145 N. West Street, Bethel 45106; 3rd Wed. monthly except in June, July and Aug.

CLINTON—Cesare A. LaRuffa, President, 215 E. Main St., Blanchester 45107; Edwin F. Bath, Secretary, 240 W. Main St., Wilmington 45177; 2nd Tuesday.

HAMILTON—Eugene J. Burns, President, 2350 Auburn Ave., Cincinnati 45219; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202; 2nd Tuesday in Sept., Nov., Jan., Feb., April and May.

HIGHLAND—Glenn B. Doan, President, 528 South St., Greenfield 45123; Walter Felson, Secy-Tres., 357 South St., Greenfield 45123; last Wednesday in July, Sept.-June.

WARREN—Gary P. Hayes, President, 109 Oregonia Rd., Lebanon 45036; Howard Berninger, Secretary, 109 Oregonia Rd., Lebanon 45036; 2nd Tues.

Second District

Councilor: James G. Tye, Dayton 45402
I.B.M. Building Suite 520

CHAMPAIGN—John R. Polsky, President, 900 Scioto St., Urbana 43078; John H. Flora, Secretary, 848 Scioto St., Urbana 43078; 2nd Wednesday.

CLARK—Ernest H. Winterhoff, President, 6 W. College, Springfield 45504; Mrs. Fonda Geer, Executive Secretary, 616 Bldg., Room 131, 616 N. Limestone St., Springfield 45503; 3rd Monday.

DARKE—Jose R. Solis, President, Wayne Hospital, Greenville 45331; Peter H. Mulder, Secretary, 6 W. George St., Arcanum 45304; 3rd Tuesday.

GREENE—Alvin Salisbury, President, 11 E. Xenia Ave., Fairborn 45324; Mrs. Clyde (Virginia) Jones, Executive Secretary, 1003 Farnell Dr., Xenia 45385; 3rd Friday.

MIAMI—Charles Gariety, President, 143 N. Sunset, Piqua 45356; A. Robert Davies, Secretary, 550 Summit Ave., Troy 45373; 1st Tuesday.

MONTGOMERY—George L. Parkin, President, 60 Wyoming St., Dayton 45409; Mr. Earl Shelton, Executive Secretary, 280 Fidelity Bldg., Dayton 45402; No regular meeting date.

PREBLE—J. D. Darrow, President, 1302 Auckerman St., Eaton 45320; J. R. Williams, Secretary, 401 N. Barron St., Eaton 45320; To be announced.

SHELBY—George J. Schroer, President, 20 S. Main St., Fort Loramie 45845; William F. Mentges, Secretary, 870 S. Main Ave., Sidney 45365; 3rd Tuesday, March, June, Sept., and Dec.

Third District

Councilor: John C. Smithson, Findlay 45840
521 W. Sandusky St.

ALLEN—G. E. Wright, President, 2551 W. Elm St., Lima 45805; Mr. Waldo Smith, Executive Secretary, Box 803, Lima 45801; 3rd Tuesday Sept. through May.

AUGLAIZE—Barbara Cummins, President, 310 Perry St., Wapakoneta 45895; Joseph Larj, Secretary, 5 E. Blackhoof, Wapakoneta 45895; 1st Thursday of each odd month except July.

CRAWFORD—Daniel P. Kenny, President, Tiffin St., New Washington, 44854; G. Wesley Bowersock, Secretary, 130 Hill St., Bucyrus 44820; Quarterly.

HANCOCK—Samuel W. Fink, President, Box 334, Mt. Blanchard 45867; Truman S. Smith, Secretary, 145 W. Wallace St., Findlay 45840; 3rd Tuesday except July and August.

HARDIN—Robert Elliott, President, 302 N. Main St., Ada 45810; L. K. Smith, 900 E. Franklin, Kenton 43326; 2nd Tuesday of each month, Sept-April.

LOGAN—Arnaldo Roldan, President, Napoleon St., Huntsville 43324; K. H. Moon, Secretary, 223 E. Columbus Ave., Bellefontaine 43311; Last Tuesday.

MARION—Raymond Concepcion, President, 1040 Delaware Ave., Marion 43305; Joseph Geiger, Secretary, 1040 Delaware Ave., Marion 43305; 1st Tuesday except June, July, August, Feb., and May.

MERCER—John W. Chrispin, President, 209 N. Main, Rockford 45828; Richard L. Dobbins, Secretary, 131 E. Fayette, Celina 45822; 3rd Thursday.

SENECA—Roberto R. Pagarigan, President, 40 Clay St., Tiffin 44883; G. W. F. Schroeder, Secretary, 26 Madison, Tiffin 44883; 3rd Tuesday.

County Society Roster (continued)

VAN WERT—N. L. Marxen, President, Medical Arts Bldg., Van Wert 45891; D. W. Walters, Secretary, Medical Arts Bldg., Van Wert 45891; Quarterly.

WYANDOT—J. J. Browne, President, 777 N. Sandusky Ave., Upper Sandusky 43351; D. P. Smith, Secretary, Pennington St., Sycamore 44882; 2nd Tuesday.

Fourth District

Councilor: George N. Bates, Toledo 43607
2102 Shenandoah Rd.

DEFIANCE—John Mitchell, President, 1400 E. Second St., Defiance 43512; Subash Mathew, Secretary, 1400 E. Second St., Defiance 43512; Quarterly.

FULTON—R. Lee Davis, President, 137 S. Fulton St., Wauseon 43567; Gerald A. Perkins, Secretary, R. #1 Box 20-A, Delta 43515; Quarterly.

HENRY—T. F. Moriarty, President, 651 Strong St., Napoleon 43545; K. E. Dye, Secretary, Box 5, Liberty Center 43532; 1st Tuesday.

LUCAS—John C. Kelleher, President, 328 22nd St., Toledo 43624; Mr. Lee F. Wealton, Executive Director, 3101 Collingwood Ave., Toledo 43610; 4th Tuesday except July and August.

OTTAWA—Detrich W. Felber, President, 730 Jefferson St., Port Clinton 43440; John F. Bodie, Secretary, 1130 Lee Ave., Port Clinton 43452; 2nd Thursday.

PAULDING—Kirkwood A. Pritchard, President, 119 S. Main, Paulding 45879; Wm. Max Miller, Secretary, Route 2, Paulding 45879; 3rd Monday.

PUTNAM—Charles B. Kidd, President, Kalida 45843; Oliver N. Lugibihl, Secretary, Pandora 45817; 1st Tuesday.

SANDUSKY—John C. Bates, President, 1937 Glen Springs Dr., Fremont 43420; Mrs. Patsy Askins, Executive Secretary, Memorial Hospital, Fremont 43420; Quarterly.

WILLIAMS—Richard L. Hess, President, Bryan Medical Group, Bryan 43506; Virgil N. Carrico, Secretary, Bryan Medical Group, Bryan 43506; 3rd Tuesday.

WOOD—Charles Smith, President, 351 Boundry, Perrysburg 43551; F. F. Householder, Secretary, 725 Haskins Rd., Bowling Green 43402; 3rd Thursday.

Fifth District

Councilor: John J. Gaughan, Cleveland 44102
7911 Detroit Ave.

ASHTABULA—R. W. Shelby, President, 524 W. 24th St., Ashtabula 44004; Miss Amy Housel, Executive Secretary, P.O. Box 1772, Ashtabula 44004; 2nd Tuesday.

CUYAHOGA—Theodore J. Castele, President, 18869 Canyon Rd., Cleveland 44126; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Ave., Cleveland 44106; 3rd Wednesday.

GEAUGA—Charles Tramont, President, 12475 Hospital Dr., Chardon 44024; Mrs. Martha Withrow, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024; 2nd Thursday.

LAKE—Joseph H. Myers, President, 36001 Euclid Ave., Willoughby 44095; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44060; 4th Wednesday.

Sixth District

Councilor: C. Edward Pichette, Youngstown 44512
1019 Boardman-Canfield Road

COLUMBIANA—Richard J. McConnor, President, 785 Aetna St., Salem 44460; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Ave., Salem 44460; 3rd Tuesday.

MAHONING—John C. Melnick, President, 1027 Boardman, Canfield 44512; Mr. Howard Rempes, Executive Secretary, 1005 Belmont Ave., Youngstown 44504; 3rd Tuesday of Jan., March, May, Sept., Nov., Dec.

PORTAGE—Donald B. Fraatz, President, Kent State Health Center, Kent 44240; A. A. Kuri, Secretary, 250 S. Chestnut St., Ravenna 44266; 2nd Tuesday.

STARK—R. J. McMahon, Jr., President, 3021 12th St. N.W., Massillon 44646; Mr. John H. Austin, Executive Secretary, 405 4th St., N.W., Canton 44702; 2nd Thursday.

SUMMIT—Charles A. East, President, 292 Exchange St., Akron 44304; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant St., Akron 44311; 1st Tuesday of Jan., March, May, Sept., and Nov.

TRUMBULL—C. M. Venetta, President, 1910 E. Market, Warren 44483; Mrs. Kay Ticknor, Executive Secretary, P.O. Box 1328, Warren 44482; 3rd Wednesday Sept. through May.

Seventh District

Councilor: Robert E. Rinderknecht, Dover 44622
404 N. Walnut St.

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MONROE—Byron Gillespie, Secretary, 158 S. Main, Woodsfield 43793. Inactive.

TUSCARAWAS—E. J. Casiano, President, 131 Fair Ave., N.E., New Philadelphia 44663; R. Hastedt, Secretary, Union Hospital, Dover 44622; 3rd Wednesday.

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Councilor: Richard E. Hartle, Lancaster 43130
414 E. Main St.

ATHENS—John F. Kroner, Jr., President, Blue Line Dr., Athens 45701; L. A. Hamilton, Secretary, 400 E. State St., Athens 45701; 2nd Tuesday in March, June, Sept., and Dec.

FAIRFIELD—Richard Hartle, President, 414 E. Main St., Lancaster 43130; David Sheidler, Secretary, 1500 E. Main St., Lancaster 43130; 2nd Tuesday.

(Continued on Next Page)

County Society Roster (continued)

(Eighth Dist. — *Contd.*)

GUERNSEY—Robert Ringer, President, 718 Steubenville Ave., Cambridge 43725; Robert O. Thiele, Secretary, Box #37, Byesville, Ohio 43723; 1st Tuesday.

LICKING—Gerald A. Erhard, President, 843 N. 21st St., Newark 43055; Dorothy Watson, Executive Secretary, Licking County Memorial Hospital, Newark 43055; 4th Tuesday except in June, July and August.

MORGAN—A. H. Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, 426 E. Union Ave., McConnelsville 43756; When called.

MUSKINGUM—Charles L. A. Wehr, President, 727 Market, Zanesville 43701; Hudnall J. Lewis, Secretary, 515 Taylor, Zanesville 43701; 1st Tuesday except in June, July and August.

NOBLE—F. M. Cox, President, Caldwell 43724; E. G. Ditch, Secretary, Box 239, Caldwell 43724; 1st Tuesday.

PERRY—Charles McDougal, President, Court House, New Lexington 43764; 3rd Thursday.

WASHINGTON—T. P. O'Maille, President, 426 Fourth St., Marietta 45750; Jose C. Alba, Secretary, 215 Marion St., Marietta 45750; 2nd Wednesday except in June, July and August.

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Holzer Med. Center, Box 344

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HOCKING—John W. Doering, Secretary, 42 N. Spring St., Logan 43138; When called.

JACKSON—John Zimmerly, President, 35 Vaughn St., Jackson 45640; Carl Greever, Secretary, 35 Vaughn St., Jackson 45640; When called.

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PIKE—R. T. Leever, President, 100 E. Third St., Waverly 45690; James Hwang, Secretary, 300 Cherry St., Waverly 45690; 1st Tuesday.

SCIOTO—Henry Rogowski, President, 717 6th St., Portsmouth 45662; Mr. Lowell E. Thompson, Executive Secretary, Scioto County Medical Society, P.O. Box 1348, Portsmouth 45662; 2nd Tuesday.

VINTON—No active society.

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104 E. Gambier St.

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MORROW—William S. Deffinger, President, State Rt. 229 W., Marengo 43334; David James Hickson, Secretary, 88 E. High St., Mt. Gilead 43338; When called.

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In This Issue:

The Brown Pharmaceutical Co., Inc. 406, 472, 480

Burroughs Wellcome Co. 427

Capital Financial Services 414

Dorsey Laboratories, Div. of Sandoz-Wander, Inc. 407, 413

Flint Laboratories, Div. of Travenol Lab., Inc. 415

International Travel Advisors, Inc. (Mediterranean Adventure) 401

Lilly, Eli and Company 418

Mead Johnson Laboratories 409

The Medical Protective Co. 406

McNeil Laboratories 469

Ohio Medical Indemnity 411

Pharmaceutical Manufacturers Association 416-417

Roche Laboratories, Div. of Hoffman-LaRoche, Inc. .. Inside Front Cover, page 399, Inside Back Cover and Back Cover

Wm. H. Rorer, Inc. 473

Searle Laboratories, Division of G.D. Searle & Co. 428-429

SK&F Co., Subsidiary of Smith, Kline & French Laboratories 430

Turner & Shepard, Inc. 468

The Upjohn Company 402-403

University Center 481

Wendt-Bristol Co. 470

Windsor Hospital 471

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W

Before prescribing, please consult complete product information, a summary which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended for children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.



Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

VOLUME 70 | AUGUST 1974 | NUMBER 8

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Original Articles

Pancreatic Pseudocysts. A Brief Review with Emphasis on Radiological Aspects. Emil Gutman, M.D., Dayton; F. P. Saranthi, M.D., Dayton; and Jerome F. Wiot, M.D., Cincinnati 495

Treatment of Operable Carcinoma of the Breast by Modified Radical Mastectomy. Edward Woliver, M.D.; Edward H. Saeks, M.D.; Ronald H. Fegelman, M.D.; and Joel Korelitz, B.S., Cincinnati 500

Squamous Cell Carcinoma of the Conjunctiva. John D. Bullock, M.D., Menlo Park, Calif.; Daniel M. Albert, M.D., New Haven, Conn.; and Stephen J. Richman, M.D., Barrington, R.I. 502

Special Article

Peer Group Review, An Educational Experience 488

American Medical Association

Report of Actions Taken at the 1974 AMA Convention 506

AMA Clinical Convention Scheduled in Portland 491

The Ohio General Assembly

Actions of Medical and Health Interest in the Ohio General Assembly 518

State Medical Board

State Medical Board's Position on Administrative Procedure 513

Ohio Medical Indemnity

OMI Maintains High Place Among Blue Shield Plans 516

Medical Golfers

Ohio Medical Golfers Stage Annual Tournament 514

Medical Education

Ground Broken for Wright State Medical School's First Building 484

Public Health

Ohio Department of Health Reports Wide Variance in Dosage for Gonorrhea 486

Woman's Auxiliary

Report of Highlights of Activities 528

Other Features

Obituaries 522

How Would You Like to Work for the Government—an OMPAC Message 524

Keeping Up: Continuing Medical Education Courses for Physicians in Ohio 526

The Journal's Advertisers

The Journal's Advertisers in This Issue 532

Classified Advertisements 533

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



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in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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VOL. 70 AUGUST, 1974 No. 8

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The Ohio State Medical Journal
600 South High Street,
Columbus, Ohio 43215

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

Subscription, $5.00 per year to nonmembers; single copy, 50 cents (outside Continental U.S., $6.50 and 65 cents).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertiser must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

Progress Climaxed with Groundbreaking Ceremonies for Coming Medical School

Advances for the Wright State University School of Medicine were capped on June 14 with the groundbreaking for the school's first building and the announcement of a million dollar gift.

Mrs. Virginia Kettering Kampf revealed the donation from the Kettering Fund at the ceremony. She is the widow of Eugene W. Kettering, Dayton philanthropist who was one of the original members of the WSU board of trustees.

Representatives of Miami and Central State Universities and of the Dayton community participated in the groundbreaking for the $2.5 million building which is known as Biological Sciences Phase Two. The two story structure will be joined later by a medical administration-classroom-library building which is now in the design stage.

The first medical school building, containing classrooms and laboratories, will be a mirror image of, and attached to, Biological Sciences Phase One, which is under construction next to the site of the groundbreaking.

The American Medical Association and the Association of American Medical Colleges have notified the University that a "letter of reasonable assurance" will be issued, which is the first step in the accreditation process. The Veterans Administration has announced that Wright State had been chosen to participate in a new program for emerging medical schools which will see $19.7 million spent in Dayton for faculty salaries at the medical school and for facilities improvement at the Dayton VA center to make the center better able to participate in the medical education program.

The groundbreaking team was unusual, for a university, in that it was composed of women only. Mrs. Kettering wielded a shovel, as did Mrs. Thelma Pruett and Mrs. Karen Schmitt.

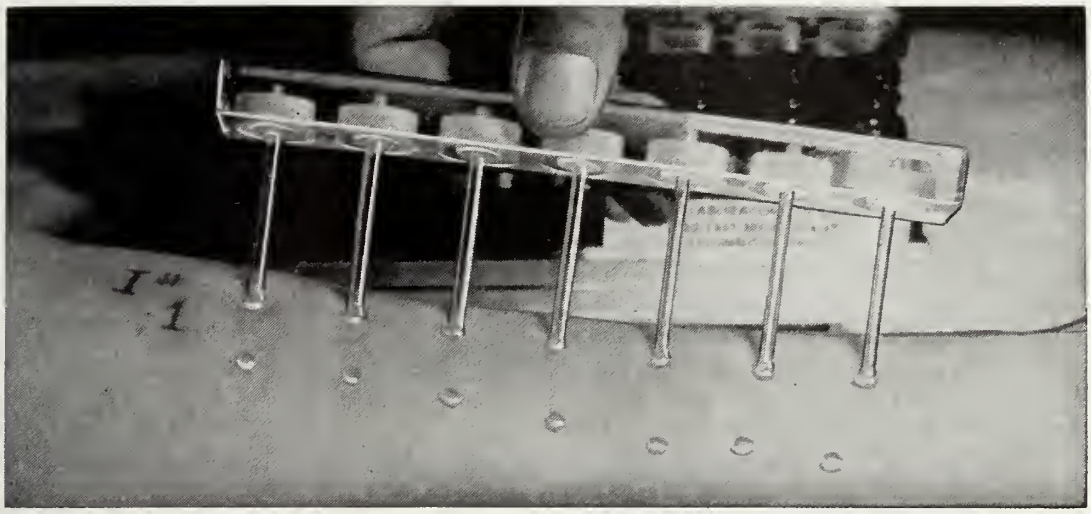
Mrs. Pruett is the widow of Thomas B. Fordham who was a Dayton General Motors executive. The Fordham foundation last fall donated $500,000 to the medical school for the Fordham Medical Library.

Mrs. Schmitt is a WSU student who had been active in the campaign for a medical school.

The estimated completion date is the fall of 1975. First students are expected to begin studies in the medical school in 1976.

Dr. Trent W. Smith, Columbus, recently was installed as president of the American Academy of Facial Plastic and Reconstructive Surgery, Inc.

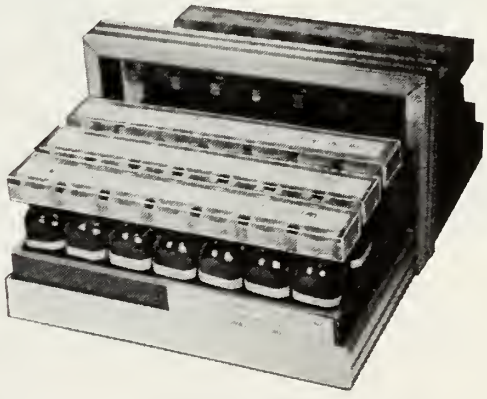
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Community Health News

Ohio Department of Health

JOHN H. ACKERMAN, M.D., Deputy Director

Treatment Schedule for Gonorrhea

A recent survey of physicians treating gonorrhea in a major Ohio city revealed a wide variance in the type and dosage of medication being used. Of those interviewed, 37 percent relied on oral penicillin preparations; and 23 percent used doses of intra-muscular penicillin which are inadequate to insure cure. Only 20 percent followed the recommended treatment schedule of aqueous penicillin and probenecid. An additional 20 percent used vibramycin, tetracycline, or spectinomycin. Not all of these were given in effective therapeutic doses.

As the practice of physicians in other areas of the State are similar to this group, more than 60 percent of persons with gonorrhea are being inadequately treated. Inadequate treatment leads to the danger of complications for the individual patient and the possibility of development of resistant strains of gonococci.

The following treatment schedule is recommended by both the Public Health Service and the Ohio Department of Health. Adherence to this schedule will insure cure in well over 90 percent of the cases.

The drug of choice for the treatment of gonorrhea is penicillin. For males or females the treatment of aqueous procaine penicillin G, 4.8 mu intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to the injection is suggested. If penicillin sensitivity occurs in the male then the treatment is 2 grams of spectinomycin intramuscularly injected. If penicillin sensitivity occurs in the female, then 4 grams of spectinomycin should be intramuscularly injected. If spectinomycin is not available then the treatment for males or females is tetracycline HC1, 1.5 grams initially, followed by 0.5 gram four times a day for 4 days, a total dosage of 9 grams. Note: When possible, probenecid should be administered as a single oral dose of 1 gram (two 0.5 gram tablets 30 to 45 minutes prior to the administration of penicillin therapy. Probenecid acts as a catalyst in increasing the blood levels of penicillin and most studies have shown a significant decrease in penicillin failure rates when this regimen is followed.

Copies of the complete treatment schedule for both gonorrhea and syphilis are available free, on request, from the Communicable Disease Division of the Ohio Department of Health.

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Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Peer Group Review, An Educational Experience

James K. Skipper, Ph.D.
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PEER GROUP REVIEW is one of the most important issues being debated in American medicine today. Welch has stated that the establishment of Professional Service Review Organizations (PSRO's) may make greater changes in the practice of medicine than any other piece of legislation in American history.[1] While this law is shrouded in controversy, many medical societies including the American Medical Association[2] and the Ohio State Medical Association[3] as well as many individual physicians have labeled it a "poor law" and called for its repeal. The American Association of Physicians and Surgeons maintains that PSRO's violate the First, Fifth, Seventh, and Ninth Amendments to the Constitution by destroying the privacy and confidentiality of the physician-patient relationship.[4] It has been said that it threatens the autonomy of the profession[5] and is degrading to physicians. Opponents maintain that it would be difficult to administer, would raise the cost of medical care, would create a massive bureaucracy, and would be susceptible to political manipulation.[6] Arguments have been presented that this law would cause either an over- or an under-utilization of services[7] and would take valuable physician time from direct patient care.[8] Finally, some believe that the PSRO legislation would stifle innovative behavior in medicine because physicians would strive to keep their practice within existing norms.[1]

Despite the widespread criticism of PSRO, few physicians oppose peer group review in principle. In fact, the medical profession has been engaged in such activities for some time. The opposition to PSRO appears to be based on the Federal Government's involvement, the punitive features of the law, and the assumed motivation behind its passage; namely, the reduction of spiraling costs of medical care rather than the improvement of its quality.

Nevertheless, one of the initial functions of the PSRO legislation has been to alert the medical profession to the presumed need for greater emphasis on the peer group review process. The suggestion has been made that the best way to live with the present law, is to work within existing systems as much as possible, especially in surveilling the quality of care in institutions.[6] Schless has further suggested that peer group review, which focuses on quality of care rather than just cost, may offer an educational challenge to physicians and be a valuable experience in continuing education. He writes:

> "The educational chart audit in the community hospital almost ideally satisfies the requirements of this type of quality control. The process of setting pattern criteria and developing a data display of actual performance is in itself a valuable educational experience requiring specific responses of an educational nature in order to correct shortcomings and narrow the gap between the optimal model and actual performance."[9]

Despite the importance of and current controversy over the establishment of PSRO's, most undergraduate medical students at the Medical College of Ohio at Toledo had very little knowledge of this legislation. They were unaware of its implications for the quality of medical care, the cost, and the utilization of health services. They had not considered how this legislation was related to peer group review and record auditing. The few students who were familiar with the law were as suspicious of its ramifications as practicing physicians and for about the same reasons as described above.

Based on the assumptions that peer group review could be made a valuable learning experience and that medical audits might be a useful methodology for developing and improving diagnosis and treatment criteria, the study of PSRO and related materials was incorporated in the curriculum during a phase of the one-month clerkship in Community and Family Medicine at the Medical College of Ohio at Toledo. The students were provided with a reading list and seminars were conducted with faculty members in which PSRO's peer group review and medical audits were discussed from both theoretic and prag-

The authors are all members of the Department of Community and Family Medicine, Medical College of Ohio at Toledo.

matic viewpoints. Also, some students actually engaged in medical auditing as their Community Medicine project.

The points of departure for the audit projects were based primarily on the works of Brook and Appel[10] and Kessner, et al.[11] Brooks and Appel define five different methods of peer group review for evaluating quality of care. They are in terms of process (what a physician does on behalf of patient) and outcome (the results of the care given to a patient). Three of the methods are called implicit; that is, they are based on expert judgments or evaluations of: (1) process, (2) outcome, and (3) process and outcome. Two methods are called explicit. Criteria for (4) process, and (5) outcome are set in advance of evaluation by experts. In their study, Brooks and Appel reviewed the care of 296 patients with urinary tract infections, hypertension, or ulcerated gastric or duodenal lesions by all five methods. They discovered that: "Depending on the method, from 1.4 to 63.2 percent of patients were judged to have received adequate care. Judgments of process using explicit criteria yielded the fewest acceptable cases (1.4 percent)."[10]

Kessner, et al, using an explicit measure of process (the method Brooks and Appel found to most discriminate), developed what they term the tracer method of evaluating ambulatory care. The assumption of the tracer method is that:

> ". . . . how a physician or team of physicians routinely administers care for common ailments will be an indicator of the general quality of care and the efficacy of the system delivering that care."[11]

They suggest a set of six tracers to evaluate ambulatory care received by a cross-section of a population—middle ear infection and hearing loss, visual disorders, iron deficiency anemia, hypertension, urinary tract infections, and cervical cancer. As an illustration, they provide a minimal care plan for hypertension.

For four months, students were assigned half-time either to physicians in family practice in the community or to the associated hospitals' ambulatory clinics. The students' projects consisted of evaluating the care of patients by applying Kessner's minimal care for hypertension to what was recorded in physician's chart.

In the initial stages of study, the students had negative attitudes toward the PSRO legislation. During the seminars, they expressed the belief that audits would be costly and increase physicians' administrative time. They did not look forward to spending time conducting an audit themselves and were less than enthusiastic about what educational value it might have. While working on the projects, however, the students came to certain conclusions which affected their attitudes toward peer group review and resulted in changes in their professional behavior.

When the students compared the hypertensive minimal care plan standard, which itemizes content of history, physical, diagnostic studies, and treatment options with the content of patient charts, they discovered first, that the patient charts were generally inadequate. Full personal and social histories were omitted. Many times blood pressure was not recorded even in the case of consecutive visits of the same patients. In other cases, there was no mention of hypertension on the charts even though patient's diastolic blood pressure was consistently high. Second, the students found that patients in a clinic setting often have more than the one illness (hypertension). With the multi-problem patient they were hampered in trying to audit hypertension independently of other diseases due to the fact that test orders were listed on the charts without any correlation of test to problem. For example, there was no way to differentiate serum lipids when the patient had hypertension, diabetes, and arteriosclerotic heart disease. Finally, the students' audit revealed that the cost to the patient of various diagnostic tests and drugs prescribed for the treatment of hypertension was not taken into account. No positive correlation was found between the cost to the patient and the length of time until the patient's hypertension was brought under control.

The students' findings are interesting and may have some implications for the future development of technics and strategies for peer group review. How well these findings may have already been assimilated by the medical community is speculative. The significance of the students' work with peer group review, however, lies not with their research findings themselves but what was learned in the process of completing the audit and the effects it had on attitudes and behavior.

The students became aware of the importance of PSRO's in terms of their possible effects on the medical profession. They became more open-minded about the legislation and were able to discuss rationally its pros and cons. One student, who was vehemently opposed to peer group review at the beginning of the clerkship, remarked shortly before the month was over: "I am still opposed to government interference in medicine, but I have to admit auditing practice is not all bad." Through the use of the audit project, the students learned something about the state of the art of evaluating the quality of medical care, the strengths and limitations of medical auditing, and the value of well-recorded, problem-oriented records. Several students remarked that although they had been informed about problem-oriented records, it was

only after the audit experience that they really were able to assess their importance.

Perhaps the most important behavioral change came in the area of record keeping. As the students progressed through their project and viewed the untidy and incomplete records kept on patient charts, their own record keeping on patients became more thorough and complete. In a student's own words:

> "When I first reviewed patients' charts with an audit on my mind, I was shocked at how sloppy they were kept. It was hard to make anything out of them. Then I looked at my own notes and found they were in no better order. I decided right then that I was going to do all I could to make mine as readable and complete as possible, even if it meant I had to type them myself."

There is little doubt in our minds that the peer group review experience was educational and very meaningful to the students. We firmly believe that they are now more ready to devote time in the future to the whole spectrum of medical care evaluation, including their own practice. We speculate that the students' experience might be duplicated with practicing physicians. If physicians could become less resentful of government's initiative in establishing PSRO's and think less about the so-called punitive features of the law, and more about the opportunities for continuing education inherent in it, and the possibilities of making improvements in the delivery of health care, the results might be as positive as we found with undergraduate medical students. Granted, the students were in a situation supposedly structured so that learning may take place and changes in attitude and behavior occur. That is part of the socialization process expected in any professional school. We suggest, however, that it is not impossible for physicians at least part of the time to look upon medical practice as a learning situation. Is this not what the concept of continuing education is all about? It would seem that in this day and age in which society is placing greater and greater pressure on all professional groups to document their competence to practice and also to keep their skills current, it would behoove physicians to be leaders in evaluating the quality of their own services. To the extent to which PSRO legislation urges and/or demands action toward such ends, we highly recommend that physicians take advantage of its opportunities for educational advancement.

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The Role of the Detail Man

Opinion & Dialogue

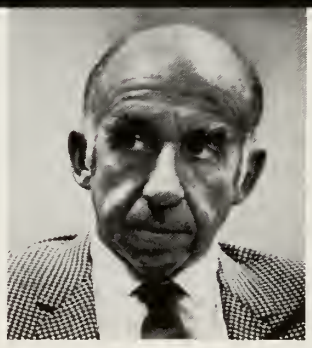


Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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Pancreatic Pseudocysts

A Brief Review with Emphasis on Radiological Aspects

Emil Gutman, M.D.
F. P. Sarathi, M.D.
Jerome F. Wiot, M.D.

PANCREATIC PSEUDOCYSTS are of interest to the physician because of their varied clinical manifestations, to the surgeon because of the innumerable operative procedures devised to treat them, and to the radiologist because of the various ways in which they manifest themselves. The purpose of this paper is to review briefly the subject of pancreatic pseudocysts with emphasis on the radiologic aspects.

By definition, pancreatic pseudocyst grossly has no true capsule nor histologically an epithelial lining. The term "pancreatic pseudocyst" is semantically unacceptable because the lesion is as much pseudo-pancreatic as it is pseudocystic.[1] They are quite uncommon as is shown in a collected study of 2,142,631 hospital admissions, which revealed an average incidence of .007 percent (151 cases),[2] and an incidence of only 2 percent in those patients with a diagnosis of pancreatitis (46 in 2173 patients).[3]

Though pseudocysts form a large majority of the pancreatic cysts, the following modified classification shows the variety of cysts encountered within the pancreas.[4]

1. Cysts resulting from defective development:
   - A. Fibrocystic disease
   - B. Associated with cystic disease of the other viscera
   - C. Simple cysts
   - D. Dermoid cysts
   - E. Disontogenic cysts—Lindau-von Hippel disease
2. Cysts resulting from disruption of pancreatic tissue either traumatic or inflammatory:
   - A. Pseudocyst
   - B. Hemorrhagic cysts
3. Retention cysts:
   - A. Traumatic
   - B. Inflammatory
   - C. Obstructive secondary to a calculus, neoplasm, or parasitic infestation
4. Neoplastic:
   - A. Cystadenoma
   - B. Cystadenocarcinoma
   - C. Degeneration in a carcinoma
   - D. Teratoma
   - E. Angiocyst
5. Cysts resulting from parasites:
   - A. Echinococcus
   - B. *Taenia solium (Cysticercus cellulosae)*

Case Reports

Case 1.—A 44-year-old Negro man with history of alcoholism and a complaint of abdominal pain had hepatomegaly on physical examination. Laboratory data:

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Reprint requests to Veterans Administration Center, 4100 West Third St., Dayton, Ohio 45428 (Dr. Gutman).
Submitted December 3, 1973.



FIG. 1. Extrinsic pressure defect on distal part of duodenal bulb (arrow) and calcifications (arrows).

serum amylase 342 Somogyi units per 100 ml, and alkaline phosphatase 67.8 King-Armstrong units per 100 ml.

Radiographs revealed calcifications almost outlining the pancreas with a deformity of the distal portion of the duodenal bulb and indentation on the gallbladder (Fig. 1).

Case 2.—A 60-year-old white man was admitted with a fractured right hip, developed jaundice and a mass in the right upper quadrant. Upper gastrointestinal series revealed a defect on the proximal portion of the duodenal bulb (Fig. 2). His serum amylase ranged from 66 to 372 units per 100 ml. A pancreatic cystogastrostomy with sphincterotomy and common bile duct exploration was done.

Case 3.—A 67-year-old white man was admitted with pain in the chest, weakness, and weight loss of 13.6 kg (30 lb). Physical examination revealed a mass



FIG. 2. Upper gastrointestinal series showing defect on proximal aspect of duodenal bulb along with calcifications in region of pancreas (arrow).



FIG. 3. Upper gastrointestinal series showing an extrinsic pressure defect on greater curvature aspect of the stomach (arrow).

in the left lower quadrant. An intravenous pyelogram showed distortion of the calyces on the left side. Upper gastrointestinal series revealed indentation on the greater curvature (Fig. 3). His serum amylase was 278 units per 100 ml and the amylase in the pancreatic fluid was 1528 units per 100 ml.

Case 4.—A 52-year-old white man was admitted with back pain radiating toward the shoulder aggravated by acids such as orange juice. He had a weight loss of 15.9 kg (35 lb) in the last six months. He admitted to consuming large amounts of alcohol. Physical examination revealed a mass in the epigastrium along with hepatomegaly. Barium studies demonstrated calcification along with extrinsic pressure defect on the lesser curvature (Fig. 4).

Case 5.—A 59-year-old white man with history of alcoholism was admitted with a complaint of diarrhea. His serum amylase was 100 units per 100 ml and the urine amylase 411 units in 60 cc. Radiographs revealed calcification of two different types—the mottled type as well as a rim type along the periphery of the cyst (Figs. 5A, B, and C). Gallbladder series showed an extrinsic pressure defect on the medial aspect (Fig. 5B). Barium



FIG. 4. Extrinsic pressure defect on lesser curvature and in antral region.

studies revealed a defect over the second and third portions of the duodenum (Fig. 5C).

Case 6.—A 33-year-old Negro man with advanced alcoholic liver cirrhosis was admitted with nausea, vomiting, hematemesis, and abdominal pain. Physical examination revealed hepatomegaly and spider angioma on the chest wall. His serum amylase was 1312 units per 100 ml. Barium studies showed a mass displacing the stomach anteriorly and downward along with calcification along the periphery of the cyst (Fig. 6A). A celiac arteriogram showed displacement of the hepatic and left gastric arteries (Fig. 6B).

Case 7.—A 64-year-old white woman was admitted with abdominal pain. She had a previous cholecystectomy and past history of gastrointestinal bleeding. On physical examination, there was a questionable mass in the right upper quadrant. Plain film of the abdomen showed a mass compressing the stomach on the lesser curvature aspect (Fig. 7). Barium studies confirmed the displacement of the stomach.

Case 8.—A 3-year-old white girl was admitted to Children's Hospital, Cincinnati, Ohio, with the diagnosis of "battered child syndrome." The films showed separation of the stomach and colon (Figs. 8A and B). The findings were judged to be on the basis of trauma. Diagnosis was pseudocyst of pancreas.

Discussion

Etiology. The causes of pseudocysts in one study included pancreatitis 72.2 percent; trauma 8.3 percent; postoperative, which includes splenectomy, gastrectomy, splenorenal shunt, and drainage procedures for chronic pancreatitis 11.2 percent; carcinoma of the pancreas 11 percent; and idiopathic 5.5 percent.[5] In the younger age group, trauma, especially of the blunt abdominal type, including the handlebar injury from a bicycle, steering wheel injury, or a kick from a horse, is the most common cause.

Localization of the Pseudocyst. The most common location for a pancreatic pseudocyst is the lesser sac between the stomach and the transverse colon bounded anteriorly by the gastrocolic ligament, between the stomach and the liver bounded anteriorly by the gastrohepatic omentum, and between the leaves of the transverse mesocolon.[6]

Other locations include posterior to the pancreas and beneath the parietal peritoneum. However, unusual locations such as the posterior mediastinum, between the layers of the sigmoid colon in the pelvis,[7] and attached to the superior pole of the left kidney have been described.[8]



FIG. 5A. Plain film showing two types of calcification along rim or periphery of cyst (arrow).

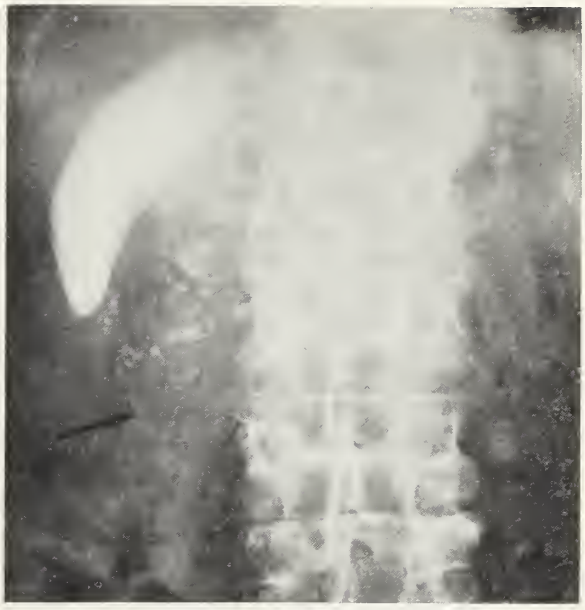


FIG. 5B. Gallbladder series showing calcification of the cyst and the defect on the medial aspect of the gallbladder.

Pathogenesis

The pancreas frequently reacts to trauma and inflammation by autolysis and formation of a pseudocyst.[9] When any of the causes already enumerated cause disruption of the pancreatic tissue,

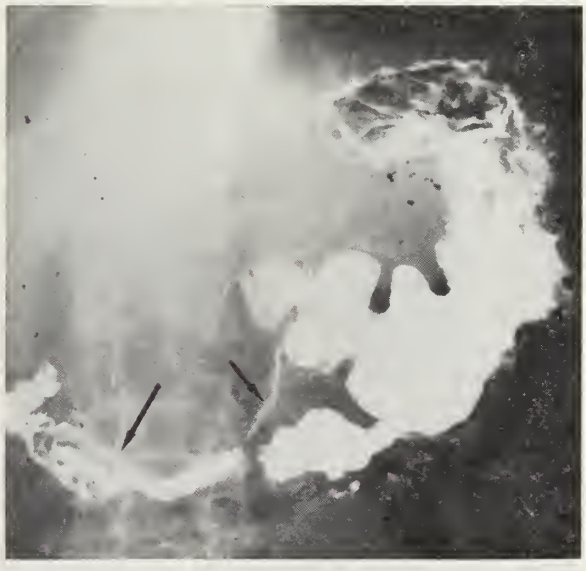


FIG. 5C. Upper gastrointestinal series showing displacement of second and third portions of duodenum (arrow).

pancreatic enzymes and blood are released into the pancreas. The liberation of these enzymes causes secretion of larger amounts of fluid by the pancreas setting up a vicious cycle. Its anterior wall gives way and the secretions accumulate within the lesser sac. This mixture of enzymes, inflammatory exudate, and debris stimulates a reactive fibrosis in the adjacent tissues and causes filling of the foramen of Winslow with resultant formation of a loculated fluid collection—"a pancreatic pseudocyst."

In the case of cysts following pancreatitis, there usually will be a lag period of 10 to 20 days for the formation of the cyst. Traumatic pseudocysts may show a tendency to decrease in size owing to the spontaneous reabsorption of fluid within about four to six weeks. However, cysts secondary to pancreatitis rarely resolve. Communication of the cysts with the pancreatic ductal system encourages further enlargement. The cysts also may become secondarily infected.

In experimental animals, it has been shown it takes about six weeks for the lesser sac to form a stabilized wall—the so-called "maturation" of the cyst.[10]

Although pseudocysts are usually unilocular, they may be multilocular in 5 percent of the cases. The size varies from 3 to 25 cm with an average of about 10 cm. In one series of 50 cases, ten were in the head of the pancreas, 28 in the body, and 13 in the tail of the pancreas.[11] The contents of the cysts include necrotic debris, milky, light amber, brown hemorrhagic fluid, or dark red clots. The organisms usually isolated include bacteroides, coagulase positive staphylococcus, *Escherichia coli,* and pseudomonas.

Clinical Features. The average age of incidence of the pancreatic pseudocysts is 42 years with a range of 3 to 84 years. There is a definite predominance of the male in most reports. In one study of 104 cases,[1] the ratio of male to female was 67:37. Symptoms in the order of decreasing incidence include abdominal pain 91, anorexia 65, nausea 61, vomiting 54, weight loss 42, and others which include abdominal tenderness, jaundice, pleural effusion, fever, and ascites. The fever usually ranges about 37.8 C (100 F). Occasionally a bruit may be heard over the abdominal mass.[12] The laboratory findings include leukocytosis, anemia, hypocalcemia, increase in the serum bilirubin, prolonged prothrombin time, increased serum alkaline phosphatase, hyperglycemia, and glycosuria. The urine amylase appears to be a better indication than the serum amylase and is increased in 30 to 50 percent of cases.[5] The urinary amylase levels generally are more than 300 Somogyi units per 100 ml and often more than 1000 Somogyi units per 100 ml. The amylase values usually return to normal after surgery and show an elevation with recurrence of the pseudocysts.

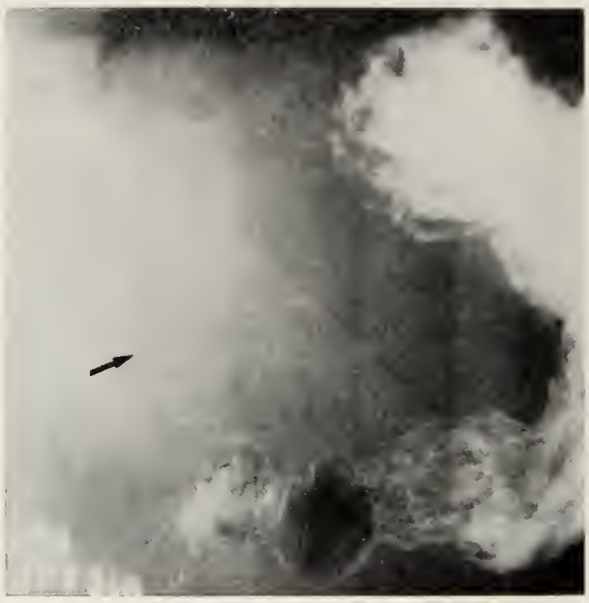


Fig. 6A. Calcification along periphery of cyst (arrow).

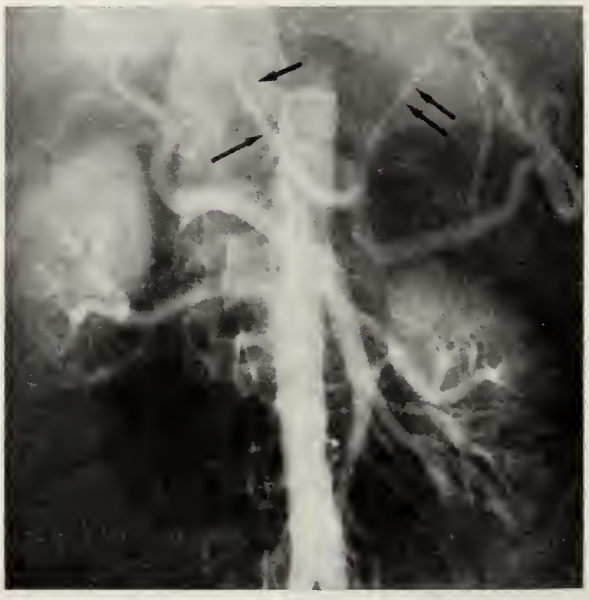


Fig. 6B. Calcification (arrow) and displacement of hepatic artery (lower arrow on right side) and displacement of gastric artery (arrows).

Associated Disease. The various associated conditions include pancreatitis, biliary tract disease, trauma, alcoholism, diabetes mellitus, gallstones, and carcinoma of the pancreas.[5,13]

Radiologic Examination

The correct diagnosis should be suggested by the radiologist in more than 75 percent of the cases, if all available studies are used, including plain

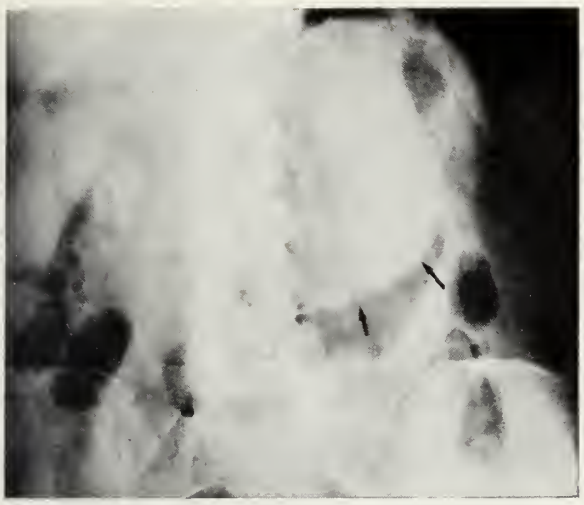


FIG. 7. Plain film showing mass encroaching upon the gas shadow of the stomach (arrows).

films, barium studies, angiography, lymphangiography, retroperitoneal air insufflation, splenoportography, and venacavography. However, in 15 percent of the cases, no abnormality is demonstrated.

Plain films of the abdomen often show a soft tissue mass (Figs. 7 and 8A). Calcification is reported in 12 to 30 percent of the pesudocysts. These may be scattered punctate calcifications (Figs. 1, 4, 5A, and 5B), or calcifications seen on a previous examination may be helpful in demonstrating formation of a pseudocyst. The chest film may be of help in showing elevation of the left hemidiaphragm with or without atelectasis of the lower lobe and a left pleural effusion (in 14 percent and 18 percent of cases respectively).[14] Bilateral pleural effusion and even a right-sided pleural effusion also have been reported.

Upper gastrointestinal series often shows displacement of the stomach, usually anteriorly, although lateral and medial displacement may be present depending on the location of the cyst (Figs. 3 and 4). Occasionally, distortion of the folds in the fundus of the stomach, the descending duodenum, and the colon also may be seen (Figs. 2 and 5C).

Impression on the duodenal sweep in the form of displacement and enlargement seen with cysts in the head of the pancreas are brought out better with hypotonic duodenography. Differentiation of the pancreatic cyst from carcinoma of the pancreas is often difficult. However, the absence of the enlargement of the gallbladder, enlargement of the common bile duct and/or Frostberg's "reverse 3" sign are more common in cases of carcinoma. Ordinarily there will be no evidence of invasion of the duodenal loop.[15]

The close association of the left kidney to the pancreas often results in displacement, dis-



FIG. 8A. Plain film showing separation of gas shadows of stomach and transverse colon.



FIG. 8B. Lateral film indicating anterior displacement of the stomach.

tortion, or indentation of the upper pole of the kidney.

In conclusion, pancreatic pseudocysts were reviewed in a period of five years from 1966 to 1971 and selected cases with characteristic radiologic appearances are reported. One feature which has not been emphasized previously is the calcification along the rim of the pancreatic pseudocyst simulating an aneurysm. Two such cases are reported, one demonstrated by selective angiography.

Summary

A brief review is made of pancreatic pseudocysts—their etiology, pathogenesis, clinical, and radiographic features. The radiologist can suggest the diagnosis in 75 percent of cases using all the available procedures, which include plain films, upper gastrointestinal series, barium enema, splenoportography, and angiography. Eight patients with characteristic displacements are briefly reported. Though the usual appearance of calcification in pancreatic pseudocysts is mottled, infrequently, it is seen along the rim of the cyst, simulating an aneurysm of the abdominal aorta. Two of the cases, one demonstrated by angiography, illustrate this rarer type of calcification.

Acknowledgment: The authors would like to express their appreciation to M.D. Yunus, M.D., for providing the material of case 7 from the Miami Valley Hospital, Dayton, Ohio.

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Treatment of Operable Carcinoma of the Breast by Modified Radical Mastectomy

Edward Woliver, M.D.
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Ronald H. Fegelman, M.D.
Joel Korelitz, B.S.

THE PROPER TREATMENT of operable breast cancer remains a problem for patient and surgeon alike. Though primed with advice from family and friends, television, and magazines, the patient lacks the medical and surgical judgment necessary to select the correct procedures. On the other hand, the surgeon must himself choose from among a number of operative technics that are each backed by impressive statistical evidence. Faced with this dilemma, the authors decided as early as March 14, 1961, that a muscle-sparing operation that removes axillary lymph nodes offered patients the best chance of cure, along with the best functional results. The purpose

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Submitted November 29, 1973.

of this article is to test our conclusions and to determine if self-evaluation in a private clinical setting can produce significant results.

The Procedure

We have adhered strictly to Haagensen's criteria for operability,[1] and have employed the following operative procedures in each case: The patient is placed on the operating room table with the ipsilateral arm extended at right angles to the body and with a small sand bag situated under the chest of the operative side. Preparation and draping are carried out and a wide excisional biopsy is taken in all cases. To avoid leakage in the operative area, the biopsy site is closed with multiple, closely placed skin sutures. While the frozen section report is being prepared, gowns, gloves, and instruments are changed. The covering sheet used at the time of biopsy is then removed and the field is expanded for the modified radical procedure. An elliptical incision is made starting at the sternum, encompassing the breast and biopsy site, carrying across the free edge of the pectoralis major muscle, and ending in the central portion of the axilla. Skin flaps are developed along the lines described by Haagensen: superiorly to the clavicle, medially to the sternum, inferiorly to the rectosheath, and laterally to the edge of the latissimus dorsi muscle. The pectoralis fascia is then excised at these margins superiorly, medially, and inferiorly, leaving the lateral attachment of the breast and fascia attached to the axillary fat pad. The costal clavicular fascia is excised sharply; muscle relaxants (succinylcholine) are given intravenously; and traction on the pectoralis major muscle is then used to expose the axillary vein and axillary content. The axilla is wiped clean of all fat from the chest wall to the point where the axillary vein crosses the white tendon of the latissimus muscle. The specimen is freed from the lateral chest wall and removed en bloc. Bleeding vessels are all tied with fine black silk sutures. The wound is irrigated with physiological saline solution; skin flaps are attached to the chest wall with fine catgut sutures, and the skin margin closed with multiple fine black sutures. No drains are used. Skin grafts have rarely been needed. The operative procedure lasts 1½ to 2 hours. Patients whose lymph nodes contain cancer are treated with cobalt postoperatively.

Aside from considerations of cure, this operation has been chosen for the following reasons: (1) No lymphatics from the breast have been demonstrated to penetrate the pectoralis major muscle directly, and removal of this muscle is not necessary for complete removal of axillary lymph nodes.[2] (2) The greatest advantage in preserving the muscles is an improved cosmetic appearance, sparing the patient the deep depressions inferior to the clavicle and the skeletonized appearance of the upper anterior chest wall. Additionally, strength in the involved upper extremity(ies) is retained.[3] (3) The incision, placed transversely and hidden in the axilla, affords a desirable cosmetic result that allows women to wear both bathing suits and off-the-shoulder dresses with little or no visible scar tissue. (4) There has been no significant lymphedema of the arm. (5) The time of operation is brief. No blood transfusions are required. (6) Postoperatively, the patients are able to be up and eating the next morning and are allowed to go home on the sixth postoperative day.

It is worth noting that no drains are used and only eight patients needed postoperative aspiration of subcutaneous fluid. All wounds healed per primam with only two patients having cellulitis, each responding to appropriate antibiotic therapy.

Results

One hundred and sixty-one patients underwent modified radical mastectomies from March 16, 1962 until July 31, 1972. This group comprised 51 premenopausal and 110 postmenopausal women. In the premenopausal group, 26 women (50.9 percent) were found to have negative lymph nodes on pathologic examination; and 25 (49.1 percent) of the women in the premenopausal group were found on pathologic examination to have positive lymph nodes. In 110 postmenopausal women, 62 (56.3 percent) were women found to have negative lymph nodes, and 48 women (43.7 percent) were found to have cancer in lymph nodes. Of 161 patients who had modified radical mastectomies,

Record of 161 Patients According to Menstrual History and Status of Lymph Nodes

Living					
Premenopausal			Postmenopausal		
+ Nodes 21	− Nodes 24	Total 45	+ Nodes 31	− Nodes 54	Total 85
Dead					
+ Nodes 4	+ Nodes 17	− Nodes 2	Total 6	− Nodes 8	Total 25

90 were available for five-year follow-up. Of the entire 161-patient group, 131 (81.3 percent) patients were alive and well; of the 90 patients available for five-year follow-up, 64 (71.1 percent) patients are alive and well. The analysis of patients' menstrual activity and the evidence of axillary lymph-node metastases in survivors can be seen in the chart.

Much attention has been given to checking patients for local recurrence, since this is a significant measurement of inadequate surgery. In the series of 161 patients, only six patients developed local skin recurrences as a first sign of metastatic disease.

Conclusion

1. Modified radical mastectomy in the hands of the authors is a satisfactory method of treating operable carcinoma of the breast.

2. Survival of 131 patients out of a group of 161 is as good as statistically possible when dealing with operable carcinoma of the breast and when compared to other large series.

3. An operation as described is easy to do, not time consuming, and is unusual in that no drains are used.

4. Routine office records can be kept and reviewed to provide a personal peer review of one's results.

Summary

A private-practice surgical office treated 161 patients with operable carcinoma of the breast; modified radical mastectomy was chosen as the method of treatment. An attempt was made to see if personal peer review was applicable in a private setting. Of 161 patients operated on, 131 were alive and well at the time of writing the review. Reasons are cited for choosing the modified radical mastectomy, and a brief description of the operative approach is given. It was felt by the authors that the operation chosen offered the patients the best chance of survival.

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Squamous Cell Carcinoma of the Conjunctiva

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Stephen J. Richman, M.D.

SQUAMOUS CELL CARCINOMA of the conjunctiva is a relatively rare lesion.[1-4] If not recognized, however, it may have serious consequence for vision and possibly for life. The authors have recently seen such a case and the patient's eye examination, hospital course, and histopathology constitute the basis of the following brief report.

Case Report

A 50-year-old black woman was seen at another hospital with a six-month history of gradually increasing pain and decreasing vision in the right eye. The best corrected visual acuity was light perception in the right eye and 20/20 in the normal left eye. External examination of the right eye revealed an extremely friable, highly vascularized fungating mass protruding through the right palpebral fissure (Fig. 1). A biopsy of this lesion revealed atypical, pleomorphic prickle cells with large nuclei and nucleoli, proliferating in a disorganized manner. Numerous mitotic figures, dyskeratosis, intracellular keratinization, and occasional epithelial pearls were evident (Fig. 2). The right eye was then enucleated and sent to the Eye Pathology Laboratory of the Yale-New Haven Hospital. The gross specimen is seen in cross section in Figure 3. The mass arises from the bulbar conjunctiva and is adherent to the cornea.

Microscopic examination shows a discrete cleavage plane at the limbus nasally, with stromal invasion temporally. An inflammatory pannus and peripheral interstitial keratitis are present. Descemet's membrane is attached over the entire extent

This study was supported in part by Public Health Service grant EY-00108-04, Public Health Service Vision Center grant EY-00785-03, and the Connecticut Lions Eye Research Foundation, Incorporated.

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Submitted December 5, 1973.

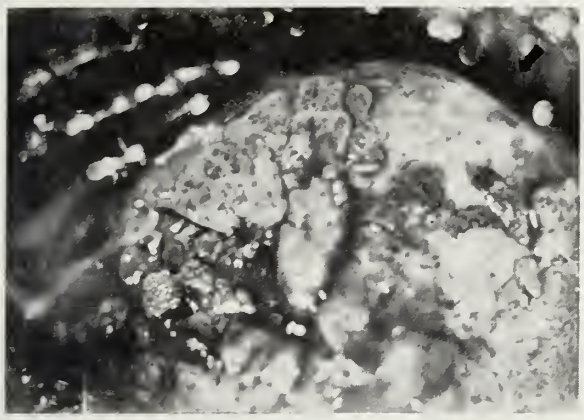


FIG. 1. External close-up photograph of patient's right eye showing an extremely friable, highly vascularized, fungating mass protruding through the right palpebral fissure. (Arrows indicate lashes of upper and lower lids.)

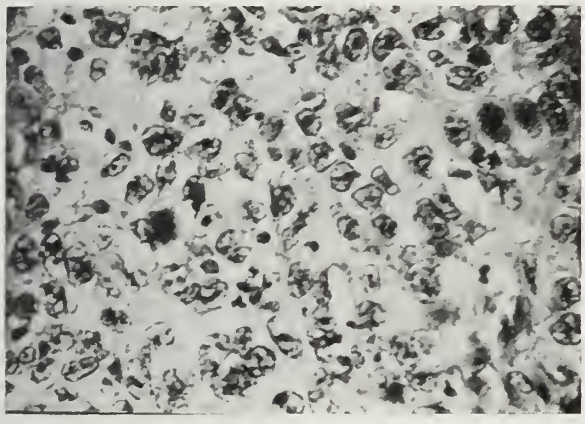


FIG. 2. Biopsy of mass in Fig. 1 showing atypical pleomorphic prickle cells with large nuclei and nucleoli proliferating in a disorganized manner.



FIG. 3. Gross cross-sectional photograph of the globe showing prominent mass adherent to anterior segment.



FIG. 4. Photomicrograph of anterior segment showing superficial corneal invasion, without intraocular extension.

of the cornea and numerous chronic inflammatory cells are seen throughout the corneal stroma (Fig. 4). No intraocular extension of the tumor is present.

Discussion

This case illustrates squamous cell carcinoma of the conjunctiva with corneal invasion. Since no intraocular extension of the tumor is present, the possibility exists that such an eye may be saved by excision of the tumor followed by a corneoscleral graft.[2] Radical surgery is not indicated in this lesion. A number of benign tumors have been confused with squamous cell carcinoma, particularly when it occurs on the eyelids.

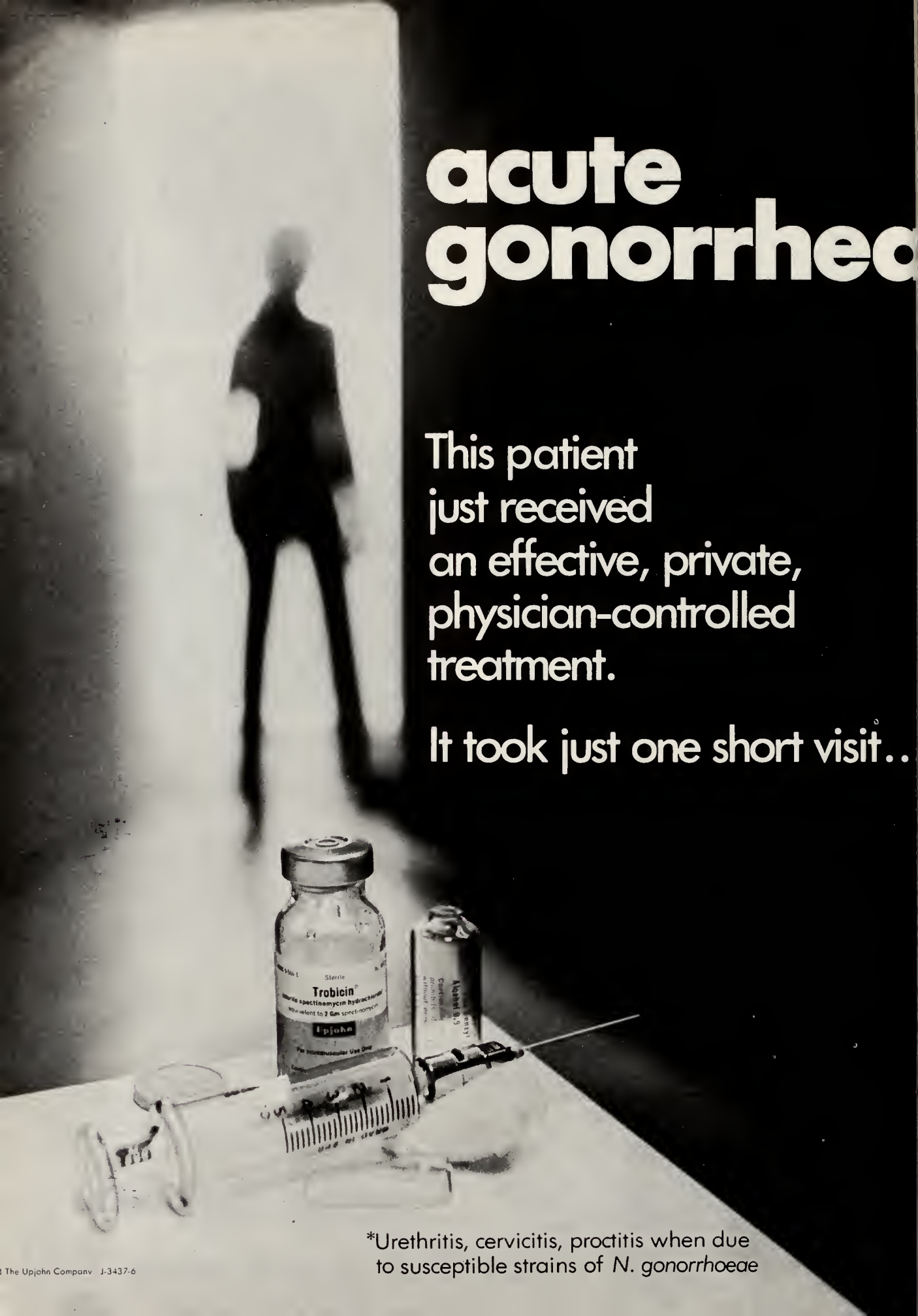
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*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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ndications: Acute gonorrheal urethritis nd proctitis in the male ond ocute gonorrheol ervicitis and proctitis in the femole when due susceptible strains of *N. gonorrhoeae*.

ontraindications: Controindicoted in poents previously found hypersensitive to spectnomycin.

Varnings: Not indicoted for the treotment of yphilis. Antibiotics used to treot gonorrheo ay mask or delay the symptoms of incubating yphilis. Patients should be carefully examined nd monthly serologicol follow-up for at leost months should be instituted if the diagnosis of syphilis is suspected.
Sofety for use in infants, children and pregnant women has not been established.

Precautions: The usuol precautions should be observed with atopic individuols.
Clinicol effectiveness should be monitored to detect evidence of development of resistonce by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinicol triols: soreness ot the injection site, urticario, dizziness, nouseo, chills, fever ond insomnio.
During multiple-dose subchronic tolerance studies in normol human volunteers, the following were noted: o decreose in hemoglobin, hemotocrit and creotinine cleoronce; elevotion of olkoline phosphotose, BUN ond SGPT. In single- and multiple-dose studies in normol volunteers, o reduction in urine output wos noted. Extensive renal function studies demonstrated no consistent changes indicotive of renol toxicity.

Dosage and administration: Keep ot 25° C ond use within 24 hours ofter reconstitution with diluent.

Male—Inject 5 ml intramuscularly for o 2 grom dose. Potients with gonorrheal proctitis and potients being re-treated after failure of previous ontibiotic theropy should receive 4 grams (10 ml). In geographic areos where antibiotic resistonce is known to be prevalent, initial treotment with 4 grams (10 ml) intramuscularly is preferred.
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For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic esistance is known to be prevalent, initial treatment with 4 grams is preferred.

Professional Activities



Report of Actions Taken at the 1974 AMA Convention

A CHANGE IN THE METHOD of electing AMA Trustees, a definitive policy statement on PSRO's, the need for additional safeguards to preserve the confidentiality of medical records, and new recommendations which affect the relationship between hospitals and hospital medical staffs were among the important items approved by Delegates at the 123rd Annual Convention in Chicago, June 23-27.

The House acted on 66 reports and 137 resolutions for a total of 203 items of business. It approved bylaws changes which replace the "slot method" of electing trustees by the "simultaneous election of candidates to several positions of equal rank," in which all candidates run for board vacancies on a single ballot.

Under the new method, trustees for full, three-year terms are elected first, followed by the selection of trustees to fill unexpired terms. Election of the AMA president-elect, vice-president, and speaker and vice-speaker of the House remains on a separate basis.

AMA Officers

Dr. Malcolm C. Todd, of Long Beach, Calif., was installed as AMA President to succeed Dr. Russell B. Roth, of Erie, Pa.

Delegates selected Dr. Max Parrott, a member of the Board of Trustees, as President-Elect, to assume the Presidency at the 1975 Convention in Atlantic City. Dr. Joseph M. Ribar, of Alaska, was named Vice-President.

Dr. Tom E. Nesbitt, of Nashville, Tenn., was reelected Speaker of the House, and Dr. William Y. Rial, Swarthmore, Pa., Vice-Speaker.

Trustees elected for three-year terms are Dr. Daniel Cloud, Arizona; James M. Blake, New York; Hoyt D. Gardner, Kentucky; Raymond T. Holden, District of Columbia (re-elected). For the unexpired two-year term of James H. Sammons, AMA executive Vice-President-Designate, Frank J. Jirka, Illinois, and for the unexpired one-year term of Dr. Parrott, Joe T. Nelson, Texas.

Actions of the House

By far the dominant issue facing the House of Delegates was the PSRO issue and interest in potential changes in the House's policy regarding this subject. Of the 137 resolutions introduced in the House, 25 dealt with the PSRO issue.

The Ohio Delegation to the AMA made every effort to strengthen the policy of the House by testimony before the committee and by efforts to introduce a proposed amendment on the floor of the House.

The Reference Committee report adopted by the House is lengthy, but is presented here in view of the prevailing interest in this subject.

Reference Committee Report

"The Committee considered 25 resolutions relating to Association PSRO policy. Most of these resolutions advocate Association activity on behalf of PSRO repeal; others call for a position for constructive amendment of and participation in PSRO, while others suggest specific amendments.

"The Committee held hearings until 5:30 p.m. arrived and no speakers remained standing. At a rough count, 64 speakers were heard. Some

were ardent for seeking repeal, while others were equally ardent against seeking repeal.

"Your Reference Committee will not present a count of speakers, or states represented on each side. It considers its responsibility to the House of Delegates to be more than simply acting as a poll taker; the Committee has weighed the testimony presented, and the background data presented, and presents *its own* reasoned conviction as to the position this Association should take.

"Your Committee notes, first of all, that this Association must take a clear-cut, definitive position which cannot be misunderstood by anyone inside or outside this House of Delegates or, indeed, by anyone inside or outside the medical profession. To do less would be to accentuate the division, almost schizophrenia, now developing within the profession, and would fail to provide the clear direction the Association's Board and this House have requested.

"Your Committee believes that this Association already has clear-cut positions in support of: 1) peer review; 2) the profession's responsibility for self-discipline; 3) professional responsibility to the patient for self-education based on quality care assessment; and, out of concern for our patients, 4) effective control of costs, secondary to preservation of quality care.

"Your Committee recognizes both the depth of feeling of those proposing an all-out repeal effort and those opposing such an effort. Primarily, because of this very depth of feeling, and the division already apparent in this House; but also because of the multiplicity and complexity of the other cost and utilization control measures available already to government *without* any mandated voice for the profession; and because of the need for this Association to retain, in the perilous times ahead, the effectiveness it has developed in recent years in dealing with Congress and the Executive Branch, your Reference Committee believes it unwise to commit the resources of the Association to an inflexible course of seeking repeal and therefore proposes the following substitute resolution:

> "**Resolved,** That this House of Delegates instruct the Board of Trustees of the Association to direct its efforts to achieve constructive amendments to the PSRO law and to ensure appropriate regulations and directives, with particular effort directed at amending those sections of the law which present potential dangers in the areas of confidentiality, malpractice, development of norms, quality of care, and the authority of the Secretary of HEW; and be it further
>
> "**Resolved,** That the Association should continue its efforts to achieve legislation which allows the profession to perform peer review in accordance with the profession's philosophy and the best interests of the patient; and be it further
>
> "**Resolved,** That individual state associations which elect nonparticipation shall not be precluded from such a position by this Association's policy statement, but should be urged to develop effective non-PSRO review programs which embody the principles endorsed by the profession as constructive alternatives to PSRO; and be it further
>
> "**Resolved,** That if ongoing evaluation of the PSRO program reveals that it does, in fact, adversely affect the quality of patient care, or conflict with Association policy, the Board of Trustees be instructed to use all legal and legislative means to rectify these shortcomings."

Ohio Proposed Amendment

It was in reference to the first resolve that the Ohio Delegation attempted to present an amendment to the foregoing resolution, but an overwhelming vote on a motion to terminate debate prevailed and the amendment could not be presented. The proposed amendment read as follows:

> Amend the First Resolve on lines 45-51, page 10 to read as follows: (deletions lined out, additions underlined)
>
> **Resolved, That the House of Delegates at the 1973 Clinical Session proclaimed the PSRO sections of PL 92-603 to have a deleterious effect on the quality of medical care and should ideally be repealed, but today recognizes the realities of the political climate and instructs** the Board of Trustees of the Association to direct its efforts to achieve constructive amendments to the PSRO law and to ensure appropriate regulations and directives, with particular effort directed at amending those sections of the law which present potential dangers in the areas of confidentiality, malpractive, development of norms, quality of care, and the authority of the Secretary of HEW; and be it further

Extension of Policy on National Health Insurance—Two statements on national health insurance were adopted after lengthy debate. One calls on the Board of Trustees to cooperate with state associations "to attempt to devise mechanisms mutually acceptable to the private medical and insurance communities which will ensure the provision of health insurance coverage through the purchase of private health insurance, and to seek means to secure favorable Congressional and public support for their adoption."

During discussion, it was pointed out that the addition to the NHI policy does not affect AMA support for Medicredit, but is intended to stimulate new health insurance mechanisms. The second resolution calls on the AMA and component associations to work to detach "any national health insurance program from the controlling intrusions of existing PSRO laws and regulations."

Support for Drug Industry, Action on FDA—The House adopted two resolutions bearing on drugs. One directs the AMA to continue its support of the pharmaceutical industry in efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy. The other resolution directs the AMA to "exert all efforts to amend or repeal the Kefauver-Harris" drug amendments of 1962, which gave the FDA broad new powers in drug manufacturing and marketing, and which critics of the FDA

contend has tended to stifle the developing and marketing of new drugs in the United States.

Oppose "Public Utility" Medicine — The House went on record as being opposed to certain bills in Congress which would replace the federal "Health Professions Educational Assistance Act" which expired June 30. Under the bills, comprehensive health planning programs would be replaced with public utility type bodies which would control certain aspects of health education and health care delivery, and medical licensure. An amended resolution adopted by the House directs the Board of Trustees to mobilize AMA membership in opposition to offensive sections of the proposed legislation, and take strong actions on other fronts.

Other Actions

In other actions affecting physicians and the government, and other third parties, the House:

Requests the AMA to work with third parties to secure increased acceptance of the AMA uniform health insurance claim form, and urges state associations to encourage acceptance of the form by insurance commissioners, and, if necessary, throught state legislation.

Urges continued AMA efforts to prevent future imposition of government fee controls, and opposes the mandatory imposition of a "Health-card" as the payment mechanism under the Administration's national health insurance plan, and instead, reaffirmed the right of the physician to bill patients directly.

Students, Interns & Residents—Two informational reports dealing with possible guidelines for housestaffs in developing contracts in institutions in which they serve generated considerable discussion before Reference Committee C. Among those testifying were medical students, residents, faculty members, hospital directors and members of the AMA's Board of Trustees and Council on Medical Service. Because of the importance and the complexity of the issues involved, the two reports, plus a revised report submitted by the Intern and Resident Business Session during the convention, were referred to the Board of Trustees for further study and consultation with appropriate groups. Delegates directed the Board to report back at the 1974 Clinical Session.

The House adopted a resolution calling on the AMA to encourage — and urging medical schools to implement — a series of lecture programs for students on the socio-economic aspects of medicine.

New Liaison Committee on Medical Education—Delegates adopted Board of Trustees Report I calling for the establishment of a new Liaison Committee on Continuing Medical Education. Structure and duties of the new committee have been worked out by AMA representatives and those representing the American Board of Medical Specialties, the American Hospital Association, the Association of Medical Specialties, and the Council of Medical Specialty Societies.

In other actions, the House:

Supported a moratorium on the licensure of allied health occupations until the end of 1975.

Adopted a report containing "Essentials of an Accredited Educational Program for the Surgeon's Assistant."

And reaffirmed the AMA's opposition to blanket pre-admission certification of hospital patients by governmental or hospital edict.

Adopted a resolution urging the AMA to support the development of preceptor programs in primary patient care to stimulate the production of more primary care physicians.

Specialty Representation in the House—In response to proposals to increase speciality representation in the House, the Reference Committee on Constitution and Bylaws reported extensive testimony, and urged "all concerned parties to increase communication, cooperation and liaison" to resolve the complex question.

The House adopted the reference committee report, and referred report H of the Board of Trustees containing proposed modifications for specialty representation in the House to the Council on Constitution and Bylaws for inclusion in its continuing study.

Malpractice Problems—A resolution calling on the AMA and constituent societies to "institute a nationwide public education program to inform the public" of malpractice problems, and for the AMA to "spearhead state and federal legislation" to correct malpractice inequities, was referred to the Board of Trustees and its Committee on Insurance for report back at the 1974 Clinical Session.

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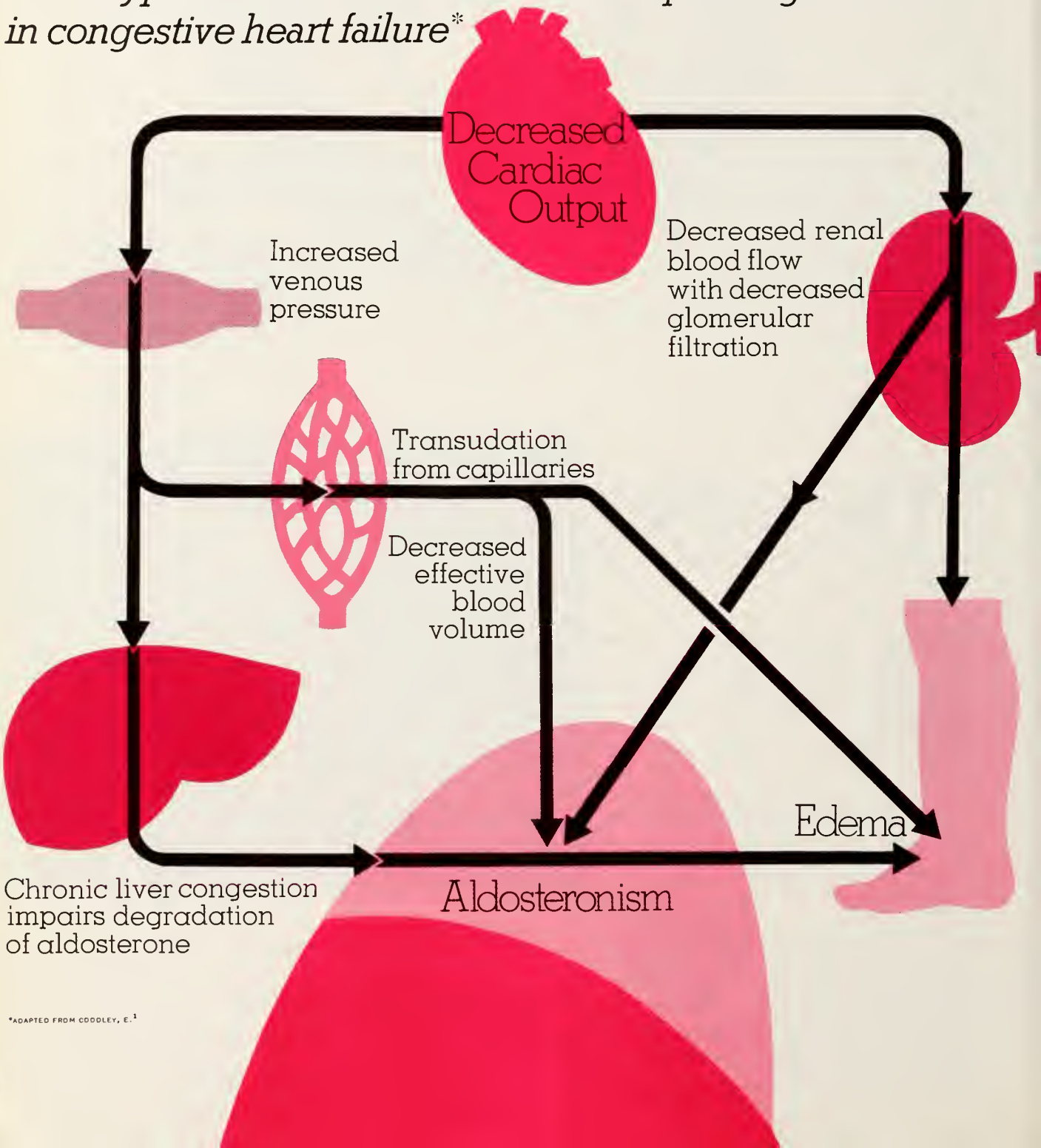
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- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide
- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: **1.** Coadley, E.: Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Lauler, D. P.: Am. J. Med. 53:673-684 (Nov.) 1972.

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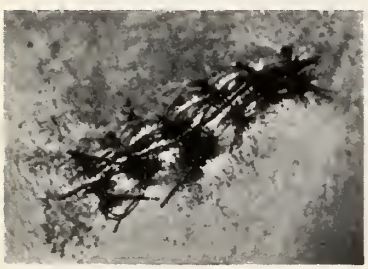
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State Medical Board's position on administrative due process

Dr. Henry G. Cramblett, president of the State Medical Board of Ohio, announced that the Board's official position on administrative due process is as follows:

"The State Medical Board, as are other state agencies, is governed by the Administrative Procedure Act (Chapter 119, Revised Code of Ohio).

"When a violation of the Medical Practice Act, (Chapter 4731, Revised Code), is alleged, the Board cannot summarily take away the license of the physician or limited practitioner against whom the allegation is made. In the case of allegations against an unlicensed practitioner, the Board's only recourse is with local law enforcement authorities.

"When a licensed practitioner or limited practitioner is charged before the Board, he must be afforded the rights of due process provided by the Constitution and by the Administrative Procedure Act. The Board cannot act on hearsay or innuendo.

"Any complainant, including Medical Societies, should furnish the Board with names of witnesses and any first hand information available.

"The Board must give the licensee formal notice of the alleged violation and he has thirty days in which to request a formal hearing. When a hearing is requested, a time must be set and the licensee given a full opportunity to present his side or position concerning the alleged violation.

"The licensee may request a continuance of the hearing date for good cause and a reasonable extension of time must then be given to avoid due process procedural problems. He is entitled to be represented by legal counsel and he may present evidence and examine witnesses for and against him. A formal record is made at the adjudication hearing.

"A hearing may extend over many days because of the complexities of the evidence and the law involved. After the hearing, the State Medical Board must reach a decision. Once the decision is reached, the licensee must be formally notified of the decision.

"If the decision is adverse to the licensee, he has a right to appeal to the Court of Common Pleas and has certain appellate rights which go to the Court of Appeals, the Supreme Court of Ohio and the Supreme Court of the United States. During the appeal, the licensee has a right to continue to practice if he can show undue hardship to the Court. Frequently this continuance or practice is granted.

"The Courts may only sustain the decision of the Board as being in accordance with law and supported by reliable, probative and substantial evidence."

In addition to examining and licensing qualified doctors of medicine and doctors of osteopathic medicine and surgery, the Medical Board also examines and licenses limited practitioners, including chiropractic, podiatry, naprapathy, spondylotherapy, mechanotherapy, neuropathy, electrotherapy, mid-wifery, hydrotherapy, suggestive therapy, psychotherapy, magnetic healing, Swedish movement, massage and cosmetic therapy.

Inquiries or complaints should be addressed to William J. Lee, Administrator, State Medical Board of Ohio, 21 West Broad Street, Columbus, Ohio 43215. Complaints should be in writing and should be signed.

Members of the Board, appointed by the Governor with the advice and consent of the Ohio Senate, are Henry G. Cramblett, M.D., Columbus; Anthony Ruppersberg, Jr., M.D., Columbus; John D. Brumbaugh, M.D., Akron; Henry A. Crawford, M.D., Cleveland; Peter Lancione, M.D., Bellaire; Sanford Press, M.D., Steubenville, and William J. Timmins, D.O., Warren.

* * *

Among other actions the Board on June 21 issued licenses to 70 Doctors of Medicine, and 11 Doctors of Osteopathy.

Ohio Medical Golfers

Ohio State Medical Golfers Association Holds Tourney; Trophy Winners in Various Categories Announced

IT WAS LIKE A TELEVISION RERUN for the Ohio State Medical Golfers Association's 1974 tournament at Canton's Brookside Country Club June 13 when overall low gross honors and overall low net honors went to the same 1973 winners.

First in a field of 137 physician golfers was Robert E. Barkett, M.D., of Mansfield, who carded a 73, a three-handicapper who won low gross in the 1973 outing, also held at Brookside.

And Thomas R. Leech, M.D., of Lima, repeated his 1973 low net honors with an 82-10-72. Dr. Barkett competed in the age 39 and under flight, Dr. Leech in the age 40 to 59 flight.

Age flight winners were:

Age 39 and under: Ralph R. Ballenger, M.D., Columbus, low gross, and B. D. Auchard, M.D., Mansfield, low net.

Age 40-49: David M. Bell, M.D., Lakewood, low gross, and H. R. Mitchell, Jr., M.D., Columbus, low net.

Age 50-59: John C. Stahler, M.D., Dayton, low gross, and Frederick I. Rose, M.D., Columbus, low net.

Age 60-69: David R. Lewis, M.D., Grove



Some of the "big swingers" pose with their trophies won at the Ohio State Medical Golfers Association 1974 tournament at Brookside Country Club, Canton, June 13. Shown are (seated, left to right) Drs. James R. Moorehead, Columbiana; Frederick I. Rose, Columbus; Robert E. Barkett, Mansfield; David R. Lewis, Grove City; John C. Stahler, Dayton; (standing, left to right) Ralph Ballenger, Columbus; David M. Bell, Lakewood; B. D. Auchard, Mansfield, and Howard R. Mitchell, Jr., Columbus. (See accompanying story for details)



Shown distributing prizes won at the Ohio State Medical Golfers Association awards banquet June 13 at Brookside Country Club, Canton, are (left to right) C. J. Shamess, M.D., Mansfield, President of the OSMGA, and Maurice F. Lieber, M.D., Canton, President-elect, Ohio State Medical Association.

City, low gross, and Jack W. Arnold, M.D., Bucyrus, and Henry C. Marsico, M.D., Lorain, tied for low net.

Age 70 and over: James R. Moorehead, M.D., Columbiana, low gross, and Homer B. Thomas, M.D., Gallipolis, low net.

Longest drive honors went to Gordon E. Gifford, M.D., Zanesville. The proximity prize was won by Carlos O. Andarsio, M.D., Springfield.

The Ohio State Medical Golfers Association was organized in 1920. Its annual outing consists of an 18-hole tournament, with a buffet luncheon "on the turn," followed that evening by a hospitality hour and an awards banquet.

President of the OSMGA is C. J. Shamess, M.D., Mansfield. The Board of Directors consists of Dr. Shamess, Dr. Bell, Dr. Stahler, Donald W. English, M.D., Lima; James S. Greetham, M.D., Marion; John A. Kramer, M.D., Ada; Edward A. Sawan, M.D., Akron, and Edward Zartman, M.D., Columbus.

Membership in the Association is open to all members of the Ohio State Medical Association. OSMA members interested in becoming members of the medical golfers organization should address their inquiries to Ohio State Medical Golfers Association, 600 South High Street, Columbus, Ohio 43215.



Frederick I. Rose, M.D., Columbus, receives a silver bowl as his trophy for low net honors at the Ohio State Medical Golfers Association tournament at Brookside Country Club, Canton, June 13. Presenting the trophy to Dr. Rose is Brookside Pro Jim Logue.

Cincinnati Cholesterol Study to Run for Seven Years

A public invitation has been issued to men ages 35 to 59 to apply for participation in a University of Cincinnati Medical Center study to determine whether reducing cholesterol levels can slow down or prevent the development of premature coronary artery disease. Prospective patients were invited to phone the Lipid Research Clinic for a telephone interview and advice as to eligibility in the program, after consultation with the person's personal physician.

Eligible volunteers will be placed in one of two groups, one group to be treated with a low cholesterol diet, the other to receive a diet and drug regimen. The program is to continue for five to seven years.

Dr. Charles J. Glueck is director of the UC Lipid Research Clinic. Drs. Ronald W. Fallat and Regine Moulton are research associates in the study.

The UC Cholesterol Study is part of a Coronary Primary Prevention Trial involving 13 other universities and a number of other agencies. The study is organized and funded by the National Heart and Lung Institute.

Ohio Medical Indemnity Maintains High Place Among Blue Shield Plans

OHIO MEDICAL INDEMNITY, the Ohio Doctors' Plan, maintained its position as the nation's fifth largest Blue Shield Plan with some increase in enrollment, the 1973 OMI annual report shows.

Following are excerpts from the report on enrollment.

Enrollment achievements in 1973 were highlighted by a breakthrough in the dental market, steady advance in total enrollment and continued progress in upgrading the membership to higher levels of coverage.

In overall results, enrollment performance was very close to that of the year before. The Plan gained 62,247 new members in 1973, compared with the addition of 60,088 in 1972. Total enrollment at year-end was 3,419,866, an increase of 1.84 percent. While modest, the increase is satisfactory in that it came during a period when the Ohio Blue Cross and Blue Shield Plans lost the State of Ohio account totaling approximately 100,000 members. The enrollment performance in 1973 solidly maintained OMI's position as the fifth largest Blue Shield Plan in the nation.

Group coverage grew by 1.74 percent, 39,891 members, in 1973, for a year-end total of 2,542,-540. Group enrollment represents approximately three quarters of total OMI enrollment. Upgrading activity continued to receive strong emphasis from OMI and its associated Blue Cross Plans in Ohio to assure that members have realistic protection against today's medical care costs. UCR coverage, as in past years, received the major upgrade attention of groups.

The number of members receiving UCR level benefits increased 110,870 in 1973 to 1,545,900. In terms of membership gain, however, UCR showed a growth for the year of 7.29 percent, compared with 25 percent in 1972 and 27 percent in 1971. This leveling of the growth curve, though seriously affected by the loss of the State of Ohio account, was to be expected as UCR became OMI's dominant group contract.

At year end, 60.27 percent of all group members held UCR level coverage. As groups moved up to UCR, OMI's scheduled indemnity contracts experienced declines in membership totals. Under intentional phasing out, the Standard contract dropped 22.96 percent in enrollment and the Preferred contract, 10.02 percent. Standard and Preferred are no longer offered for sale. The $450-schedule Major and Select contracts showed a combined decline as well, dropping 6.65 percent. Special and National contracts—individually designed coverages that do not fit into any of the regular categories—increased 56.18 percent, 27,080 members, in enrollment.

Major Medical was an important area of enrollment activity in 1973. Nearly 82,450 members added these supplemental benefits to their basic group coverage. This produced an enrollment gain of 11.53 percent, bringing total Major Medical enrollment to 784,448. In the last quarter of the year Ohio's Blue Cross and Blue Shield Plans introduced new versions of Major Medical. Benefit maximums were raised from $20,000 to $250,000 and co-payment and deductible provisions revised to increase the member's protection against the costs of truly catastrophic illnesses.

The area of greatest interest and highest growth rate in 1973 was dental coverage. Starting the year with only 1,000 contracts, dental enrollment increased seven-fold by year end. Capping the year was the selection by OMI by General Motors as insurance carrier for a dental program covering some 200,000 hourly employees and family members starting October 1, 1974.

Enrollment of billed-at-home members increased 2.11 percent in 1973 to 877,326. The Standard Contract, being phased out, decreased by 9.6 percent. The Preferred Contract, sold as companion coverage to Medicare, increased 3.18 percent and the '450' contract by 2.78 percent. Recognizing a need and desire by many non-group members for improved levels of protection, developmental activity was conducted during the year for introduction, in 1974, of a non-group UCR contract.

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Governor John J. Gilligan is shown signing the "Fifth Pathway" bill for American medical students trained in foreign countries to get Ohio licenses. Standing with the Governor are David Rader, left, Director of the OSMA Department of Legislation, and Representative Arthur R. Bowers (D-Steubenville), prime sponsor of the bill.



Senator Clara E. Weisenborn (R-Dayton), prominent figure in the Ohio General Assembly and now chairman of the important Senate Committee on Education and Health, has been very helpful to the medical profession in legislative matters pertaining to medicine and health.

Actions of Medical Interest by the Ohio General Assembly

By David Rader, Director
OSMA Department of State Legislation

THE SECOND SESSION of the 110th General Assembly (1974) has recessed for the summer to allow time for campaigning for the Fall General Elections. Bills enacted during the first session (1973) of this Assembly were discussed in the November 1973 issue of the *Ohio State Medical Journal.*

Legislative issues which were of special interest to OSMA members this year included bills to mandate departments of family practice in Ohio's four medical schools, to transfer the Bureau of Crippled Children's Services from the Department of Public Welfare to the Department of Health, to provide a "Fifth Pathway" for American medical students trained in foreign countries to get Ohio medical licenses, to change the medical emergency authorization forms used in Ohio's schools, and to enact new abortion legislation.

H.B. 474, Hale (D-Columbus), mandates the establishment of departments of family practice in any tax supported medical school in the State of Ohio. Currently that would include Ohio State University, University of Cincinnati, Case Western Reserve, and the Medical School of Ohio at Toledo. In the near future, this would also affect the two new medical schools in Dayton and the Akron area. The bill further requires that the medical schools establish family practice residency programs in community hospitals that are affiliated with the universities.

Ohio's Bureau of Crippled Children's Services has been transferred from the Department of Public Welfare to the Department of Health under provisions of **H.B. 1138,** Speck (R-New



House leadership was very instrumental in helping to promote good health legislation this year. From left are: Majority Floor Leader Barney Quilter (D-Toledo); Speaker of the House A. G. Lancione (D-Bellaire); and Speaker Pro Tem Vernal G. Riffe, Jr., (D-New Boston).

Concord). This legislation is a result of action on the part of many providers of service to crippled children in the State of Ohio and has been endorsed by the OSMA. It places the Bureau of Crippled Children's Services with the Division of Maternal Health of the Ohio Department of Health, and portions of the new law require a medical professional advisory committee to assure that there will be continuation of high quality medical care under the program.

American medical students who attend medical school in a foreign country and who desire to return to the United States for the last two years of their training may do so and then become licensed in Ohio under the provisions of **H.B. 1008,** Bowers (D-Steubenville). This bill makes the AMA approved "Fifth Pathway" program acceptable for licensure in the State of Ohio. The "Fifth Pathway" program allows a student who is an American citizen and who has received classroom training in a foreign medical school to return to the United States for clinical and internship training in lieu of social service in that foreign country, after which time he may sit for the licensing examination.

H.B. 1175, Cox (D-Barberton), makes a number of changes in the emergency authorization form for school districts. The original emergency authorization form was passed during the first session of the 110th General Assembly as **H.B. 168,** Camera (D-Lorain), but school districts felt the need for a number of minor changes and those were included in **H.B. 1175.**

Ohio's new abortion laws became effective as a result of **H.B. 989,** Wilkowski (D-Toledo). The new law prohibits abortions except by physicians; establishes a new crime of abortion manslaughter for purposely taking the life of a child born by attempted abortion who is alive when removed from the uterus of the mother or for failure to take measures required by the exercise of medical judgment in light of the attending circumstances to preserve the life of a child who is born alive when removed from the uterus of the mother; permits an unwed mother to obtain an abortion without the father's consent; and gives the Public Health Council authority to establish rules and regulations on abortion and post-abortion procedures. There is currently an action in the courts to declare portions of this bill unconstitutional and it is very possible that new abortion legislation will be necessary during the 111th General Assembly.

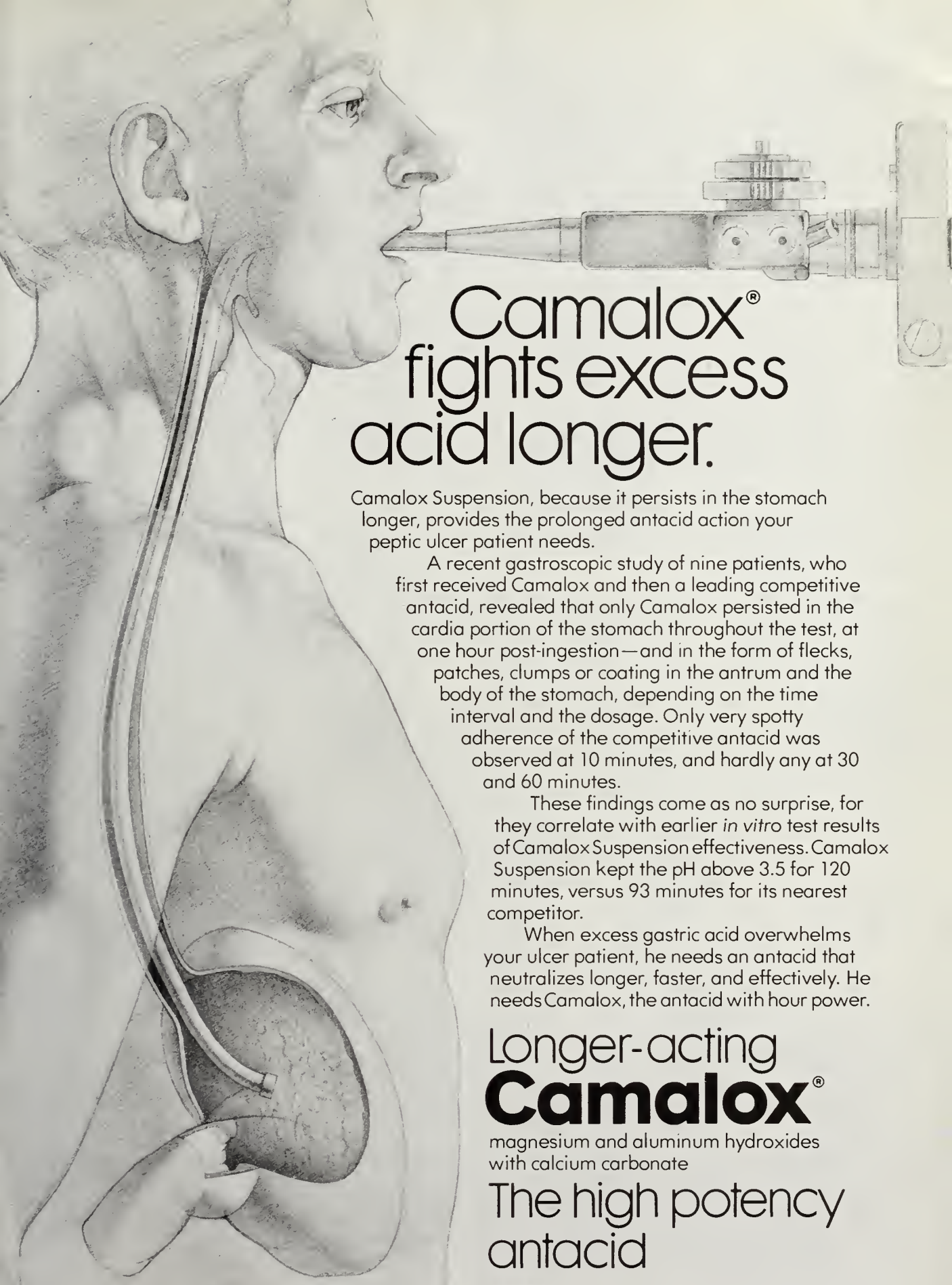
Bills which did not pass the Legislature include **S.B. 212,** Ocasek (D-Akron), to establish a separate licensing board for chiropractors. The OSMA has been opposed to this piece of legislation and it has been stalled in the Senate Rules Committee. Other bills of interest that did not

pass include a number of physician's assistant bills, a bill to permit minor consent for pregnancy advice and a bill to establish a medical student loan commission.

Legislators who were especially helpful to the OSMA during this session included Senator Clara Weisenborn, of Dayton, and Representative Sam Speck, of New Concord. Senator Weisenborn, as Chairman of the Senate Education and Health Committee, was instrumental in seeing to it that a number of good bills were efficiently processed and she carried a number of legislative items on the floor of the Senate during Senate debate. Representative Speck, as a member of the House Health Committee, was instrumental in many areas of health legislation attempting to streamline governmental involvement in health issues and was especially diligent in making necessary changes in the delivery of health services to crippled children.

Representatives David Hartley, of Springfield; Art Bowers, of Steubenville; and Joan Douglass of Mansfield, carried a number of health related legislative issues and should be congratulated for their hard work. Senators Howard Cook, of Toledo, and Douglas Applegate, of Steubenville, saw to it that OSMA issues in the Senate moved along as quickly as possible. Leadership in both Houses is to be congratulated for diligent work on issues relating to health. They include House Speaker A. G. Lancione, of Bellaire; House Speaker Pro Tem Vernal G. Riffe, Jr., of New Boston; Majority Leader Barney Quilter, of Toledo; Minority Leader Charles F. Kurfess, of Bowling Green; and Assistant Minority Leader Norman A. Murdock, of Cincinnati. Senate leadership was President Pro Tem Theodore M. Gray, of Columbus; Majority Whip Michael J. Maloney, of Cincinnati; and Minority Leader Anthony O. Calabrese of Cleveland. Assistant Minority Leader Oliver Ocasek, of Akron, was especially active during the latter part of the session when illness prohibited Senator Calabrese from performing his duties.





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Obituaries

Edward Samuel Ellis, M.D., Cleveland; Pritzker School of Medicine of the University of Chicago, 1948; age 59; died May 1.

Thomas John Ball, Sr., M.D., Cincinnati; University of Cincinnati College of Medicine, 1930; aged 72; died June 19; member of OSMA and AMA.

Edward John Devins, M.D., Cincinnati; University of Cincinnati College of Medicine, 1936; aged 63; died June 8; member of OSMA and former member of AMA.

Loren Lee Frick, M.D., Canton; Ohio State University College of Medicine, 1915; aged 83; died June 20; member of OSMA and AMA.

Robert Wilson Gregg, M.D., Cardington; Wayne State University School of Medicine, 1927; aged 76; died May 25; member of OSMA and AMA.

Rolla Edwards Hoffman, M.D., Duarte, Calif. (formerly of Leipsic, Ohio); Western Reserve University School of Medicine, 1913; aged 86; died May 4.

Robert Heazlit Lechner, M.D., Berea; Western Reserve University School of Medicine, 1934; aged 66; died May 25; member of OSMA and AMA.

William Frederick Mitchell, M.D., Wooster; Western Reserve University School of Medicine, 1926; aged 75; died June 12; member of OSMA and AMA.

Ernest Eugene Rhoads, M.D., Cincinnati; University of Cincinnati College of Medicine, 1933; aged 71; died May 29; member of OSMA and AMA.

Salem Shaheen, Jr., M.D., Canton; University of Cincinnati College of Medicine, 1949; aged 50; died June 8; member of OSMA and AMA.

Marvin D. Shie, Sr., M.D., Cleveland; Western Reserve University School of Medicine, 1944; aged 80; died June 21; member of OSMA and AMA.

Frederick Amos Snyder, M.D., Ft. Lauderdale, Fla. (formerly of Cincinnati); aged 76; died May 21; member of OSMA and AMA.

Richard Willett Solier, Bryan; Ohio State University College of Medicine, 1936; aged 65; died June 2; former member of OSMA.

Harold E. Stricker, M.D., Marysville; University of Michigan Medical School, 1932; aged 69; died June 23; member of OSMA and AMA.

Theodore M. Wille, M.D., Lakewood and Cleveland; University of Pennsylvania School of Medicine, 1931; aged 69; died May 29; member of OSMA and AMA.

Milton Wolpert, M.D., East Liverpool, Ohio, and Chester, W. Va.; Rush Medical College, 1930; aged 71; died June 12; member of OSMA and AMA.

William Wallace Young, M.D., Chillicothe; Hahnemann Medical College of Philadelphia, 1928; aged 74; died April 4.



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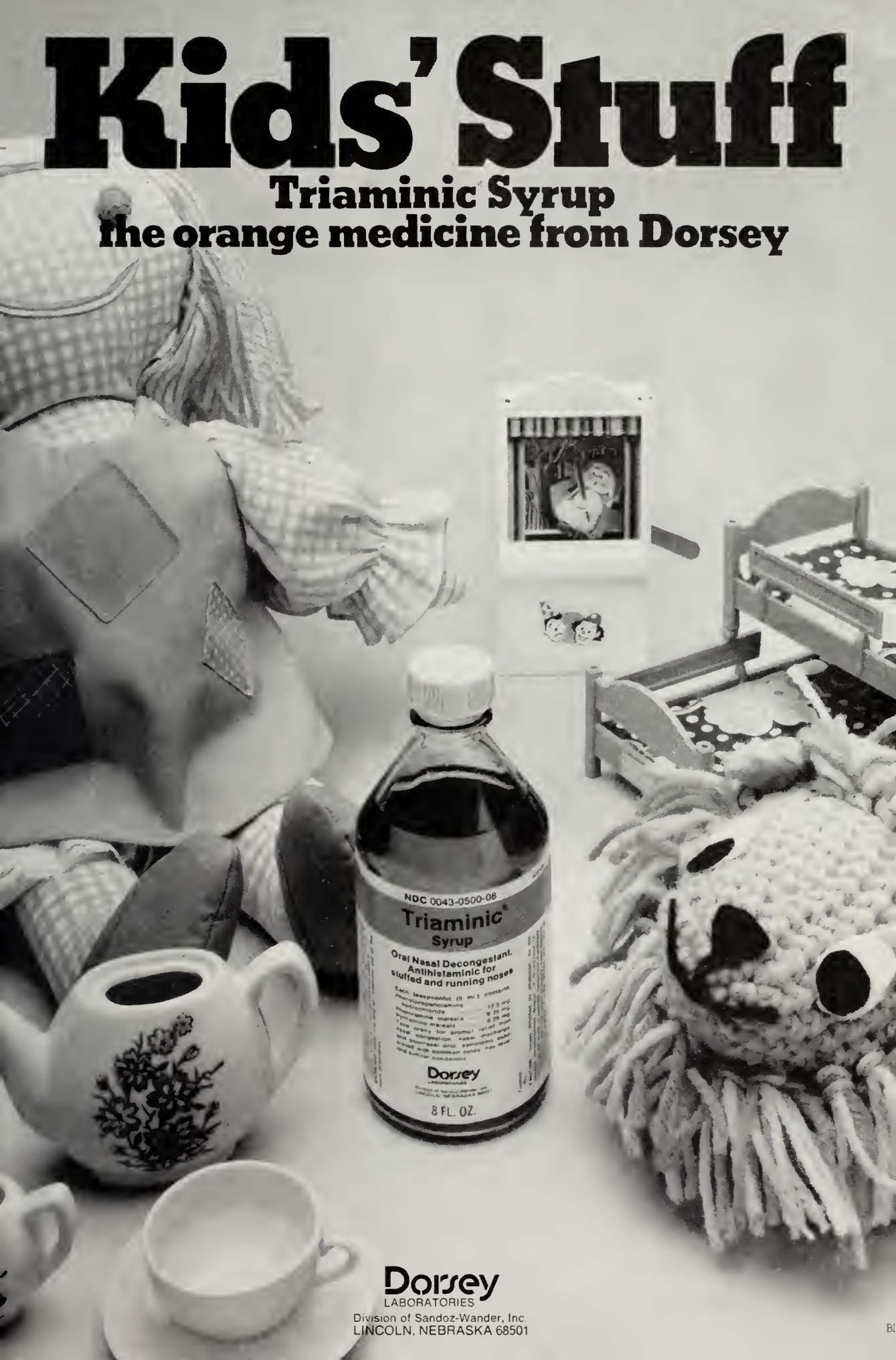
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Ohio Academy of Family Physicians Annual Scientific Assembly—Cleveland Plaza Hotel, August 8-11; contact Mrs. Florence Landis, Executive Director, Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214.

Association of Philippine Practicing Physicians in America — Annual Convention, Aug. 16-18, Holiday Inn North Randall, 4600 Northfield Rd., Cleveland. For further information, write or call F. V. Barnes, M.D., P.O. Box 8292, N. Royalton, Ohio 44133.

September

Pediatrics and the Practicing Physician — Symposium sponsored by the Medical College of Ohio at Toledo and the Toledo Pediatric Society, Sept. 20-22, at Sheraton Westgate, Toledo. For additional information, write: Howard S. Madigan, M.D., MCO, P. O. Box 6190, Toledo 43614.

Ohio Regional Meeting, American College of Physicians — Holiday Inn-Ohio State University, Columbus, Sept. 20-21. Contact: William H. Bunn, Jr., M.D., 4025 Whippoorwill Way, Youngstown 44505. This is one of numerous sessions being held throughout the continent. For data about other courses, contact American College of Physicians, 4200 Pine St., Philadelphia, Pa., 19104.

Third Teaching Skills Workshop, sponsored by the OAFP at the Imperial House North, Morse Road at I-71, Columbus, Sept. 27-28; contact Mrs. Florence Landis, Executive Director, Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214.

October

Association of Physicians of the State of Ohio, Quarterly Session — Juvenile Diagnostic Center, Columbus, Oct. 17-18. Contact: Virginia S. Edwards, M.D., Secretary-Treasurer, 347 Lexington Ave., Mansfield 44907.

American Association for Laboratory Animal Science—25th Annual Meeting, Cincinnati Convention-Exposition Center, Cincinnati, Oct. 21-25; contact: Executive Secretary Joseph J. Garvey, AALAS, 2317 W. Jefferson St., Suite 208, Joliet, Illinois 60435.

Reye's Syndrome—Sponsored by the Children's Hospital Research Foundation; at the Neil House, Columbus, Oct. 29-30; contact: J. Dennis Pollack, Ph.D., 215 Ross Hall, The Children's Hospital, 561 South 17th St., Columbus 43205.



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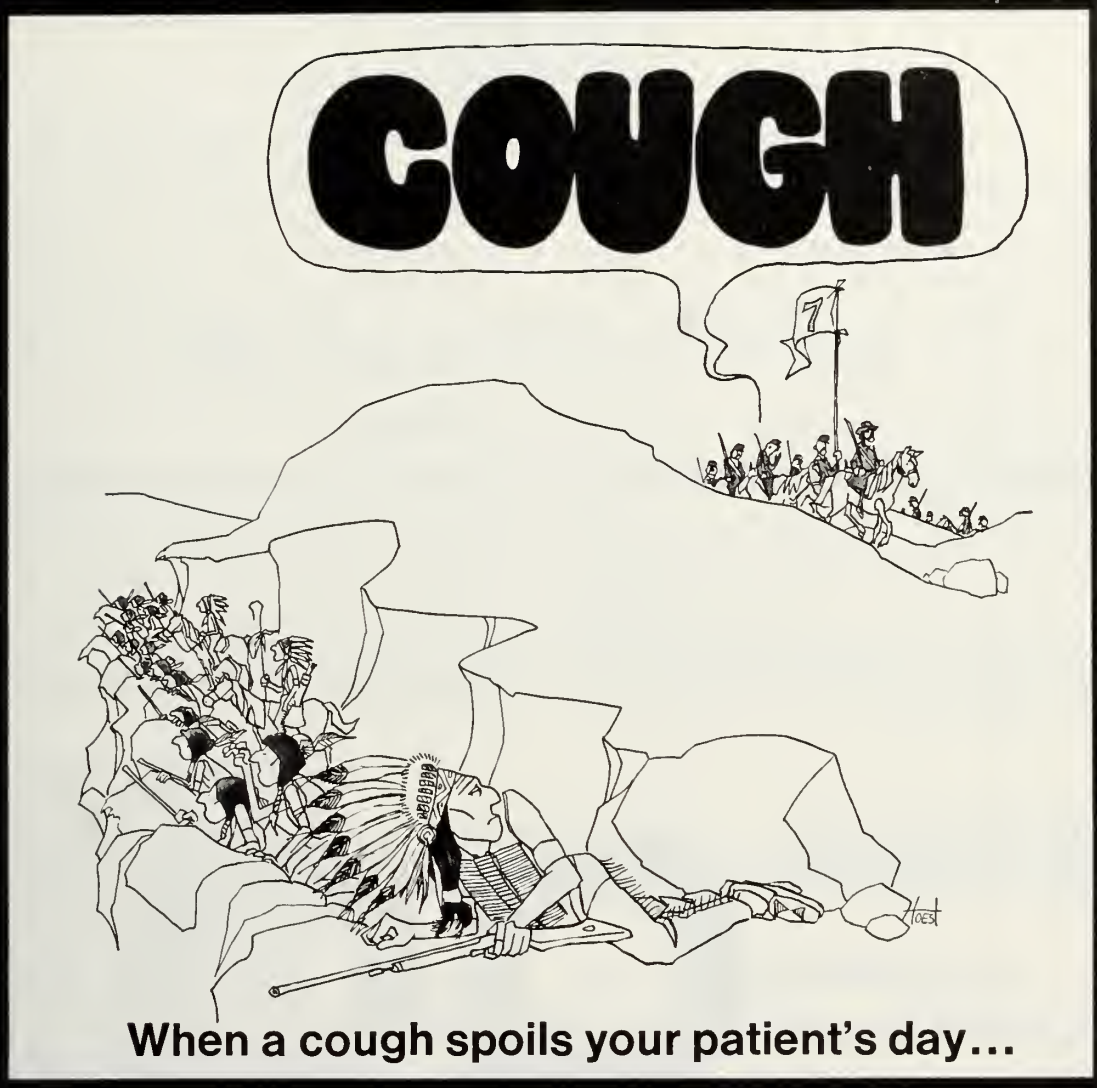
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Woman's Auxiliary Highlights

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OHIO HAD A NICE SHARE of the spotlight this year at the fifty-second annual convention of the Woman's Auxiliary to the American Medical Association held in June at the Drake Hotel in Chicago. Mrs. Malachi W. Sloan, II, a past state president and past North Central Regional Legislation Chairman, was elected to the National Board of Directors. She will also be serving as North Central Regional Communications Chairman. Mrs. Louis Loria, 1972-73 state past president, was appointed North Central Regional Health Education Chairman. Mrs. J. Paul Sauvageot, another Ohio past president, continues as editor of MD'S WIFE, our national magazine. Mrs. Karl Ulicny, 1973-74 president, served on the convention Election and Tellers Committee, was the presidential delegate from Ohio and gave her state's report.

In addition, Ohio won Honorable Mention for contributing the next-to-the-largest amount to AMA-ERF—some $90,000. Isn't that something? As usual, first place went to California whose membership just about doubles ours!! We received another AMA-ERF award—the one given to states coming up with a ten dollar or more per capita record. Ours was $16.41. The merit award was in the form of a beautiful pewter plate on which was inscribed "Health, Love, Wealth and Time to Enjoy Them."

There was, of course, the traditional Ohio Breakfast at which Mrs. S. J. Glueck, 1974-75 state president, presided. This is always a very special occasion—the "breaking bread" at 7:30 in the morning of our delegates and special guests. I didn't "make" the convention this year, but from frequent past participation I know what a high spot it is and how much the get-together means. This year there were unusual place cards, courtesy

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REFER TO PDR

of Jane Sloan, and red carnation corsages, courtesy of Charlotte Glueck's mother.

Mrs. Howard Liljestrand, of Hawaii, is the new national president. (I'm told that the Hawaii delegation honored Mrs. Liljestrand and the national auxiliary in sumptuous fashion!) Mrs. Erle Wilkerson of Tennessee is the new president-elect. At the installation of Dr. Malcolm C. Todd as president of the American Medical Association, another "first" happened. All the state auxiliary presidents were seated in a group on the balcony just to the side of the stage, in full view of the audience. Dr. Todd recognized these auxiliary presidents and asked them to stand as he honored them. Later there was a reception honoring Dr. and Mrs. Todd and Dr. and Mrs. Liljestrand. Membership in the national auxiliary is 89,440.

Joyce Brothers, Ph.D., well-known television personality, spoke about marriage and family as the keynote speaker. "We must choose the future," she said, "rather than letting it happen to us . . . . women should think of themselves as persons first to live in the changing world—then they should think of their husbands and then their children." She delved into the past of family and marriage, into the now and into the future. Another speaker was Virginia Apgar, M.D. and Ph.D., who spoke on genetic counselling. She is the senior vice-president of the National Foundation-March of Dimes. Charlotte Glueck described Dr. Apgar as "very warm, witty and possessed of considerable charisma." Another convention speaker was W. Phillip Gramm, Ph.D., who discussed energy and inflation. "We must break the back of PSRO," he said. "It represents totalitarianism and is an indication of what is to come." He did go on to say that in spite of everything, this is a time for optimism and action — "we can turn America around." In speaking of a National Health Insurance Plan, he said that when health care is free, people tend to overuse it. He feels that if the Insurance Plan is adopted, fantastic demands will be made.

Delegates from Ohio in addition to Mrs. Ulicny as presidential delegate included: Mrs. S. J. Glueck who served as chairman of delegates, Mrs. Frank Anzinger, Mrs. Paul Chrenka, Mrs. Christopher Colombi, Mrs. Henry Crawford, Mrs. Carl Frye, Mrs. Carl F. Goll, Mrs. Jerry Hammon, Mrs. Kenneth Harshman, Mrs. Edward Kieger, Mrs. Vincent LaMaida, Mrs. Louis Loria, Mrs. Herman Lubens, Mrs. William Myers, Mrs. J. Paul Sauvageot, Mrs. Malachi W. Sloan and Mrs. Russell Wiessinger.

Back to Ohio

Each year our state AMA-ERF committee works hard at selling such items as stationery, umbrellas, toys, dolls, place mats, jewelry, kitchen knick-knacks and a host of other items. This is done to raise money to cover the inevitable expenses of the committee (it is important to remember that every cent contributed to AMA-ERF is sent to AMA-ERF!) This year's effort was even more successful than usual. I am advised by Mrs. Henry Holden, 1973-74 chairman, that not only did her committee raise enough for the incurred expenses but, for the first time, had an additional three hundred dollars left over to make its own contribution to AMA-ERF! Orchids to you-know-who . . . .

They're In Order

What else—but delighted and appreciative congratulations to Jane Sloan, Eileen Loria and Ludel Sauvageot. These three are representing Ohio on the national level and who can blame us for being very proud indeed?

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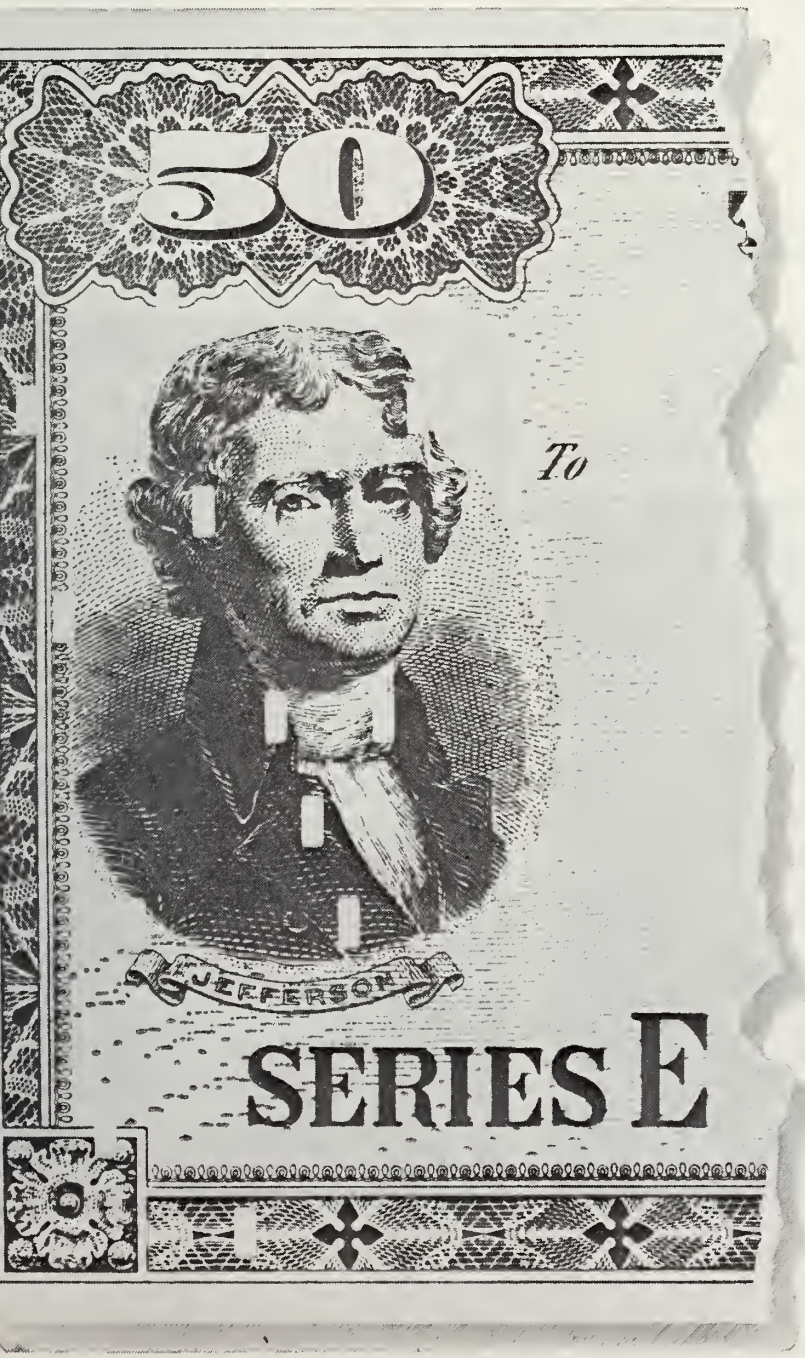
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In This Issue:

Allergy Laboratories of Ohio 485

The Brown Pharmaceutical Co., Inc. 520, 529, 532

Burroughs Wellcome Co. 512

Jean Crutchers Antique Shows 490

Daniels-Head & Associates, Inc. 528

Dista Products Co., Div. of Eli Lilly and Company 494

Dorsey Laboratories, Div. of Sandoz-Wander, Inc. 517, 523, 527

Flint Laboratories, Div. of Travenol Lab., Inc. 509

Harding Hospital 524

Lilly, Eli and Company 494

Loma Linda Foods 509

McNeil Laboratories 525

Mead Johnson Laboratories 487

The Medical Protective Co. 529

Pharmaceutical Manufacturers Association 492-493

Roche Laboratories, Div. of Hoffman-LaRoche, Inc. ...Inside Front Cover, page 483, Inside Back Cover and Back Cover

Wm. H. Rorer, Inc. 521

G.D. Searle & Co. 510-511

Turner & Shepard, Inc. 530

University Center 533

The Upjohn Company 504-505

Wendt-Bristol Co. 522

Windsor Hospital 526

Wolman Insurance Agency, Inc. 486

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PSYCHIATRIST—Serve as Medical Director to North Central Community Mental Health and Retardation Services of Franklin County, a newly funded mental health center. Must be Board certified or Board eligible in psychiatry. Licensed or eligible for licensure in Ohio. Responsible for medical services of center; participate in administrative process; provide consultation to service component directors; provide psychiatric consultation to staff professionals; assure appropriate admissions to inpatient service; participate in treatment; susupervise psychiatric residents. Faculty appointment to medical center. Salary $37,000. Write including resume to C. Dan Miller, Executive Director, 233 S. High Street, Columbus, Ohio 43215.

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The Bactrim™ edge

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

A high assurance of clinical efficacy

- in cystitis, pyelonephritis and pyelitis diagnosed as chronic
- against susceptible strains of the common urinary tract pathogens, usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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in cystitis, pyelonephritis and pyelitis diagnosed as chronic and due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which appears on preceding page.

The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

VOLUME 70 SEPTEMBER 1974 NUMBER 9

Original Articles

Gastric Polypectomy. Case Report of Removal Via the Fiberoptic Endoscope. Philip Edlin, M.D., Cincinnati 557

Cryptococcosis of Bone. Case Report. Miguel A. Pedraza, M.D., Springfield 559

Maternal Health in Ohio: Maternal Mortality Report for Ohio—1971. By the OSMA Committee on Maternal Health 563

Your State Society at Work

What the OSMA Council Did at Its July 27-28 Meeting 571

Introducing New Members of OSMA 540

Introducing OSMA's Expanded Field Service and Its New Director 582

Definition of the Physician's Assistant in Ohio Is Approved by The Council 577

OSMA Executive Director Named to Board of National Executive Group 550

In Ohio's Medical Colleges

University of Cincinnati College of Medicine Dedication Scheduled 570

University Vice-President and Medical Center Director Named in Cincinnati 536

All Health Sciences Programs at OSU Put Under New Vice-Presidency 536

Research in Ohio

Progress Reported in Cleveland Cystic Fibrosis Study 548

OSU Gets Major Regional Cancer Research Center 583

Your AMA at Work

New Society Will Boost Voluntarism by Physicians 562

AMA Inaugurates Medical Scholarships 583

Public Health

Ohio Department of Health Reports on Immunization Month (October), Expanded Pap Test Program 542

Keeping Up

Continuing Medical Education Courses for Physicians in Ohio 546

Taxation

IRS Reverses Ruling Concerning Deductible Travel Expenses 552

Woman's Auxiliary

Woman's Auxiliary Highlights 586

Other Features

A Glimpse into the Past 548

Obituaries 584

The Journal's Advertisers

The Journal's Advertisers in This Issue 590

Classified Advertisements 591

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Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Ohio State MEDICAL JOURNAL

VOL. 70 SEPTEMBER, 1974 No. 9

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Address All Correspondence:
The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215

Published monthly under the direction of The Council for ond by members of The Ohio Stote Medicol Association, 600 South High Street, Columbus, Ohio 43215, o scientific society, nonprofit orgonization, with o definite membership for scientifc ond educationol purposes.

Subscription, $5.00 per yeor to nonmembers; single copy, 50 cents (outside Continental U.S., $6.50 ond 65 cents).

Entered as second class matter July 5, 1905, ot the Post Office ot Athens, Ohio, under the Act of Congress of Morch 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postoge Poid ot Athens, Ohio.

The Journol does not assume responsibility for opinions expressed by the essayists. Advertiser must conform to policies ond regulations established by The Council of the Ohio Stote Medical Association.

Publicotion office: 900 Eost Stote Street, Athens, Ohio 45701.

Printed by
The Lowheod Press, Inc., Athens, Ohio

All Health Sciences Programs at Ohio State Put Under New Vice-Presidency

An administrative reorganization of the health sciences at Ohio State University received approval of the university's Board of Trustees at a meeting on July 12.

For the first time, a member of the President's Staff—with the new title of vice-president for health sciences—will serve as chief administrative officer for all of the health science programs offered in five colleges—Dentistry, Medicine, Optometry, Pharmacy and Veterinary Medicine. He will be directly responsible to President Harold L. Enarson.

The new vice-presidency for health sciences will replace the vice-presidency for medical affairs, under which programs of the College of Medicine only are presently administered.

Dr. Richard L. Meiling served as vice-president for medical affairs until his retirement on June 30, and Dr. Henry G. Cramblett, dean of the College of Medicine, was named to the vice-presidency in an acting capacity.

University Vice-President and Medical Center Director in Cincinnati Named

Dr. Stanley B. Troup in July succeeded Dr. Edward A. Gall as vice-president of the University of Cincinnati and director of the University Medical Center. The UC Medical Center includes Cincinnati General and Holmes Hospitals, the College of Medicine, Nursing and Health, and Pharmacy.

Dr. Troup has been Physician-in-Chief of the Rochester General Hospital, Rochester, N.Y., and Professor of Medicine in the University of Rochester School of Medicine. He has been an Alfred P. Sloan fellow at the Sloan School of Management of the Massachusetts Institute of Technology, and is a member of the visiting faculty of the Sloan School's program in the dynamics of health systems.

Dr. Troup is the third Director of the Medical Center since it was established in January, 1962. His predecessors are Dr. Clement F. St. John, who retired in 1970, and Dr. Edward A. Gall. Dr. Gall retired June 30 after serving with distinction as Professor and chairman of the Department of Pathology, as well as Vice-President and Director of the Medical Center.

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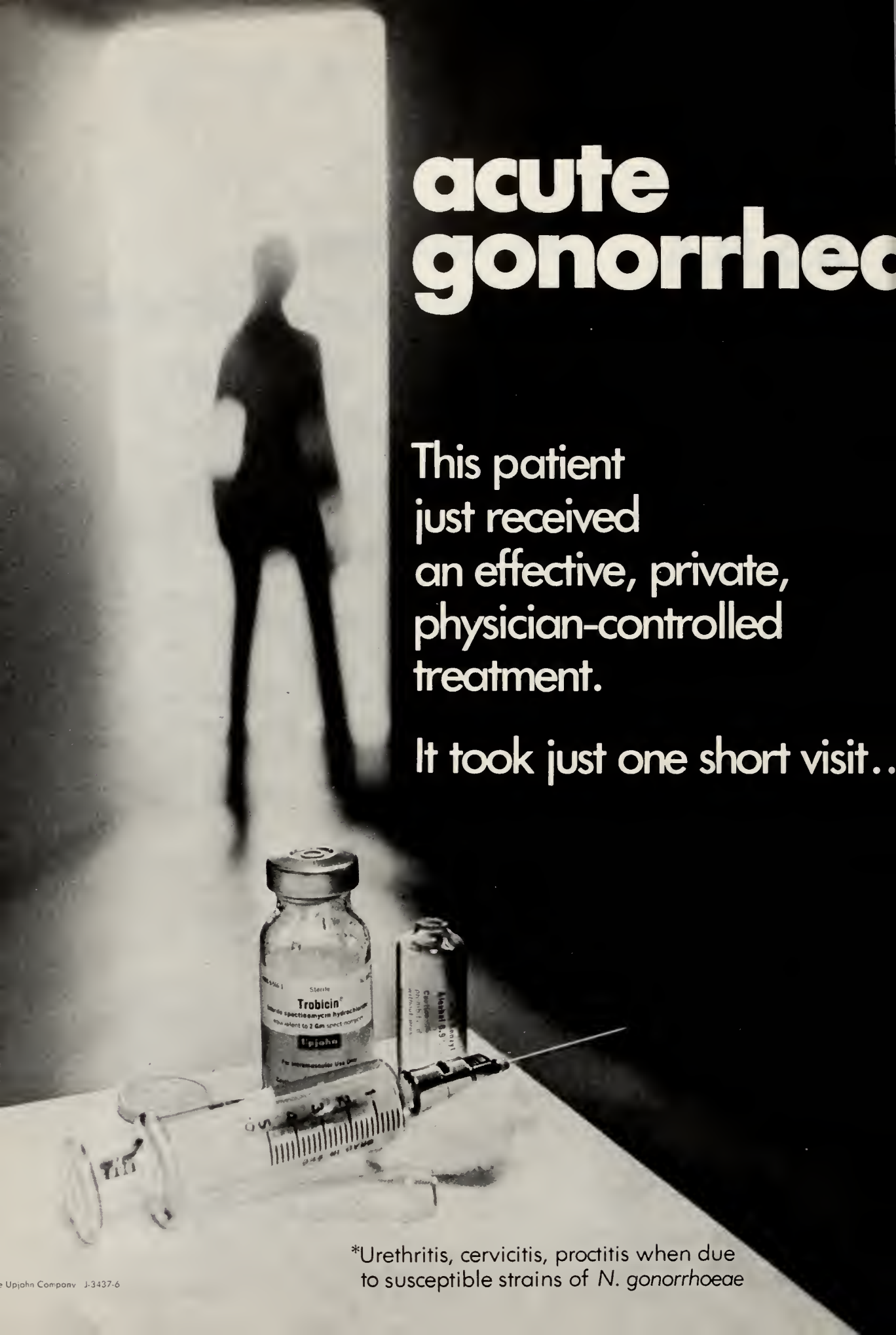
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*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
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Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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..and Trobicin®

2 gm and 4 gm vials

sterile spectinomycin hydrochloride

terile Trobicin
terile Trobicin (spectinomycin hydrochloride) For Intramuscular Injection:
gm vials containing 5 ml when reconstituted ith diluent
gm vials containing 10 ml when reconstituted ith diluent.
n aminocyclital antibiotic active *in vitro* against ost strains of *Neisseria gonorrhoeae* (MIC 7.5 20 mcg/ml) Definitive *in vitro* studies have own no cross resistance of *N gonorrhoeae* etween spectinomycin and penicillin.

ndications: Acute gonarrheal urethritis nd proctitis in the male and acute gonorrheal rvicitis and proctitis in the female when due susceptible strains of *N. gonorrhoeae*.

ontraindications: Contraindicated in pa-nts previously found hypersensitive ta spec-nomycin.

Varnings: Not indicated for the treatment of philis. Antibiotics used to treat gonorrhea ay mask or delay the symptoms of incubating philis. Patients should be carefully examined nd monthly serological follow-up for at least months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in narmal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dase studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated na consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 haurs after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentratian of 400 mg spectinomycin per ml (as the hydrachlaride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn

MED B-5-S (MBR-I)

The Upjohn Company, Kalamazoo, Michigan 49001

For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic esistance is known to be prevalent, initial treatment with 4 grams is preferred.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during May and June. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

ALLEN
Harley B. Negin
Lima

AUGLAIZE
Victor J. Stegall
New Bremen

COLUMBIANA
Samrith Laornual
East Liverpool

CRAWFORD
Sang Woo Ha
Bucyrus

CUYAHOGA (Cleveland)
Ruben T. Agra
Kamal N. Barsoum
Harry L. Bremer
Jeffrey W. Bullard
Nelida R. Enrique
Serafin C. Garcia, Jr.
Thomas C. Gruen
Thomas J. Haverbush
Tak-On Ko
Bohdan Kupczak
Marvin Kupelson
Elroy D. Kursh
Frederico M. Manuel
Rogelia B. Medidas
Daniel R. Neagoy
William J. Reinhart
Bernardo T. Reyes
Gustavo Rincon
Robert J. Sokol
Prasankumar J. Vasavada
William J. Witt

FRANKLIN (Columbus)
Robert E. Frank Jr.
Joseph T. Spare

GALLIA
Kenneth J. Billings
Gallipolis

HAMILTON (Cincinnati except as noted)
Steven T. Langheim
Fort Thomas, Ky.
Walter G. Moster
Jose E. Otero-Martinez
Alvaro H. Rojas
Alfredo S. Suntay
Dummi P. Yathiraj

LAKE
Jun-Ja Chung Park
Painesville
Aboutaleb Rastgoufard
Cleveland

LORAIN
Douglas J. Lee
Lorain

LUCAS (Toledo)
Jagadish S. Jhunihunwala
Toledo
Emilio A. Espinosa
Ramon Rodriguez-Torres

MAHONING
James W. Finn
Warren

MIAMI
Victoria G. Ocampo
Troy
Norma I. Pattugalan
Troy

MONTGOMERY
Murray D. Kuhr
Dayton
Alireza Marandi
Dayton

PORTAGE
Stanley W. Olsen
Kent

SENECA
Azael P. Borromeo
Tiffin

SUMMIT
Linda L. Reed Alston
Medina
Charles Joseph Coven
Akron
Robert W. Patti
Cuyahoga Falls
Charles Edmund Ross
Cuyahoga Falls
Howard David Shapiro
Akron
John Nelson Hutzler
Akron

WOOD
Manuel L. de La Serne, Jr.
Bowling Green

* * *

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during July. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CUYAHOGA (Cleveland)
Arthur C. J. Brickel
Tak Keung Chow
Chun Kull Chung
John Paul Conomy
Vincent Dovico
Jon Curtis Lochner
Charles James Nowacek
Erdulfo Paz Paat
Suhas G. Parulekar
Marc Alfred Pohl
Naronk Rodwarna
Mortimer G. Rosen
Pedro Y. Sy
Sisenando O. Yap
James Michael Marrs
Harry Russell Maxon, III
Michael Jay Rozen
Jeffrey Steven Schwam
Bahram Ziaie

HAMILTON (Cincinnati)
Melvin Seth Gale
Ann Roberta Gelke
John Karl Krieg
Richard David Levin

LUCAS (Toledo)
Manuel S. Bernardo
Nirmal Bhargava
Charles C. Church
Eduardo V. Shea

MONTGOMERY
Makram Issa Gobrail
Dayton

SCIOTO
Henry W. Hogan, Jr.
Portsmouth
Ronald R. Turner
Portsmouth

Occupational Medicine

The American Occupational Medical Association is the new name of the former Industrial Medical Association, the name being changed at the annual business meeting in Bal Harbour, Fla., May 1. The association was organized in 1916 as the American Association of Industrial Physicians and Surgeons.

Dr. C. Craig Wright took office as president at the meeting. An Ohioan, Dr. Wright was the first recipient of the OSMA Family Practice Scholarship. Early in his career he chose aviation and industrial medicine as his field. He is presently health services and medical director of the Information Technology Group, Xerox Corporation, Rochester, N.Y.



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BO-SD

Community Health News

Ohio Department of Health

JOHN H. ACKERMAN, M.D., Deputy Director

Immunization Action Month

For the second year in a row, October has been selected as the focal point for a national "Immunization Action Month." This is a cooperative effort to reverse the alarming trend of declining immunization levels among 1-4 year old children against polio, measles, rubella, diphtheria, pertussis, and tetanus through intensive educational and motivational programs. A host of public and private health agencies, voluntary service groups, pharmaceutical firms, and the Center for Disease Control have joined together to carry out a two-part campaign. This campaign will be directed at private and public health care providers and parents for the purpose of increasing immunity among the inadequately immunized, or unimmunized preschool age population.

To coincide with this national effort, the Ohio Department of Health will prepare and channel promotional materials through the mass media and community operations.

Private physicians are encouraged to:

(1) audit their preschool age files and ascertain that those children in need of additional immunization will receive them.

(2) provide individual record cards to parents of those children receiving immunizations.

(3) meet with local health officials and form a cooperative promotional campaign relative to the immunization levels and need in their community.

(4) to speak concerning immunization at meetings, on television, or on radio.

Pap Test Program Expanded

The National Cancer Institute has awarded the Ohio Department of Health a contract to make Cervical Cancer Detection Services more widely available to low-income women—especially for women who have never had a "Pap" Test or for women who had a "Pap" Test longer than one year ago. A sum of $299,977 has been granted for the first year of the three-year program. Twenty Target and 17 alternate counties were selected on the basis of:

1. No clinical services of any kind (hospitals, clinics, physicians) for adult women.

2. Counties with highest mortality from Cervical Cancer.

3. Counties with some clinical services (hospitals, physicians, clinics, but none providing "Pap" tests for women over the child bearing age) and having a higher percent of

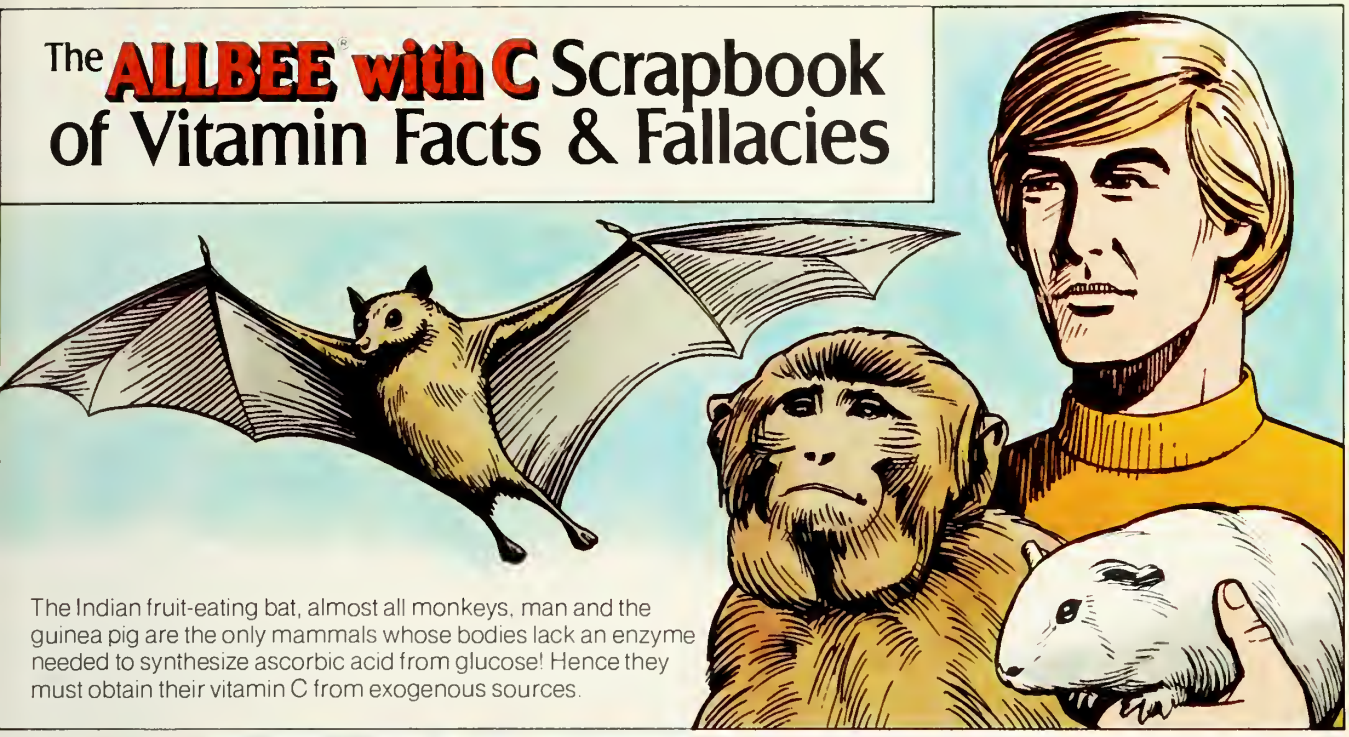
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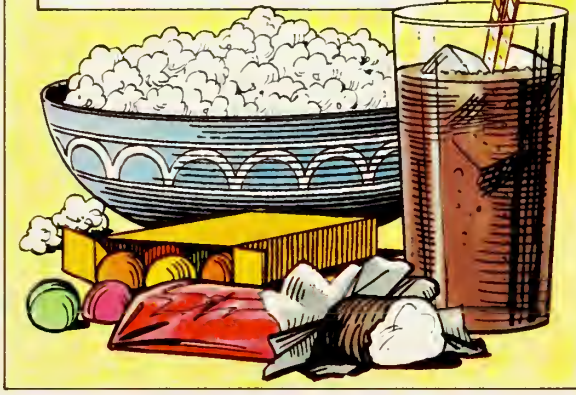


The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.



De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.

A 1965 U.S.D.A. survey revealed that American diets were lower in vitamin C than they had been 10 years earlier!





The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

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hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital (warning: may be habit forming)	(¼ gr.) 16.2 mg	(½ gr.) 32.4 mg	(¾ gr.) 48.6 mg.

Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

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families below the poverty income level (according to the 1970 census, $4,000 per year for a family of four).

4. Counties with clinics for specific rural population demonstrating a need for expansion.

Twenty County Cervical Cancer Clinics are being developed or enlarged through the local health departments or Family Planning Units. The local "Core" part-time personnel (M.D., Nurse, Clerks, and Out Reach Worker) will conduct a minimum of two clinics a month. Women with a positive "Pap" test will be recalled for a second test. Those with a confirmed "Pap" test will be referred to their personal physician. The grant covers a fee for diagnostic services. The local health agency guarantees nursing follow-up services and assistance when needed in making arrangements with the Welfare Department for payment for treatment.

Services will be available to women age 16 and over, with special emphasis on the women over the child bearing age where the danger of invasive cancer of the cervix is greater. Women will be recalled for a yearly "Pap" test.

The Department of Pathology, College of Medicine, Ohio State University will provide the Cytopathology services.

The Department's Division of Chronic Diseases is conducting the program, and is working cooperatively with the American Cancer Society, Ohio Division and their local chapters to make Cervical Cancer detection services more widely available to the high risk women in Ohio.

NEWS NOTES

Dr. Russell C. Long, of Mansfield, was the subject of a recent feature article in the *Mansfield News Journal*. Appalled by the lack of adequate health facilities in Haiti, he has undertaken a personal mission to see that a modern hospital is built there. Dr. Long flies his private plane to Haiti frequently to bring modern medical treatment to underprivileged natives.

The Department of Pediatrics of the University of Louisville is presenting its eighth annual newborn symposium entitled "Symposium on Drugs in the Newborn" on November 7 and 8. For details write: Dr. Billy F. Andrews, 200 East Chestnut Street, Louisville, Ky. 40202.

The University of Miami (Florida) is offering the second annual Pediatric Nephrology Seminar January 2-7; a course on Human Disease Related to Food and Chemical Sensitivity, Jan. 29-31; and a course, Hypertension, Diabetes and Hyperlipidemia in Childhood and Vascular Disease in the Adult, March 11-14, 1975. For details, contact: Division of Continuing Medical Education, University of Miami School of Medicine, P.O. Box 520875 Biscayne Annex, Miami, Florida 33152.



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Continuing Education Opportunities for Physicians in Ohio

September

Pediatrics and the Practicing Physician — Symposium sponsored by the Medical College of Ohio at Toledo and the Toledo Pediatric Society, Sept. 20-22, at Sheraton Westgate, Toledo. For additional information, write: Howard S. Madigan, M.D., MCO, P. O. Box 6190, Toledo 43614.

Ohio Regional Meeting, American College of Physicians — Holiday Inn-Ohio State University, Columbus, Sept. 20-21. Contact: William H. Bunn, Jr., M.D., 4025 Whippoorwill Way, Youngstown 44505. This is one of numerous sessions being held throughout the continent. For data about other courses, contact American College of Physicians, 4200 Pine St., Philadelphia, Pa., 19104.

Third Teaching Skills Workshop, sponsored by the OAFP at the Imperial House North, Morse Road at I-71, Columbus, Sept. 27-28; contact Mrs. Florence Landis, Executive Director, Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214.

October

Association of Physicians of the State of Ohio, Quarterly Session, in the Columbus area, place to be announced, Oct. 17-18. Contact: Virginia S. Edwards, M.D., Secretary-Treasurer, 347 Lexington Ave., Mansfield 44907.

American Association for Laboratory Animal Science—25th Annual Meeting, Cincinnati Convention-Exposition Center, Cincinnati, Oct. 21-25; contact: Executive Secretary Joseph J. Garvey, AALAS, 2317 W. Jefferson St., Suite 208, Joliet, Illinois 60435.

Reye's Syndrome—Sponsored by the Children's Hospital Research Foundation; at the Neil House, Columbus, Oct. 29-30; contact: J. Dennis Pollack, Ph.D., 215 Ross Hall, The Children's Hospital, 561 South 17th St., Columbus 43205.

November

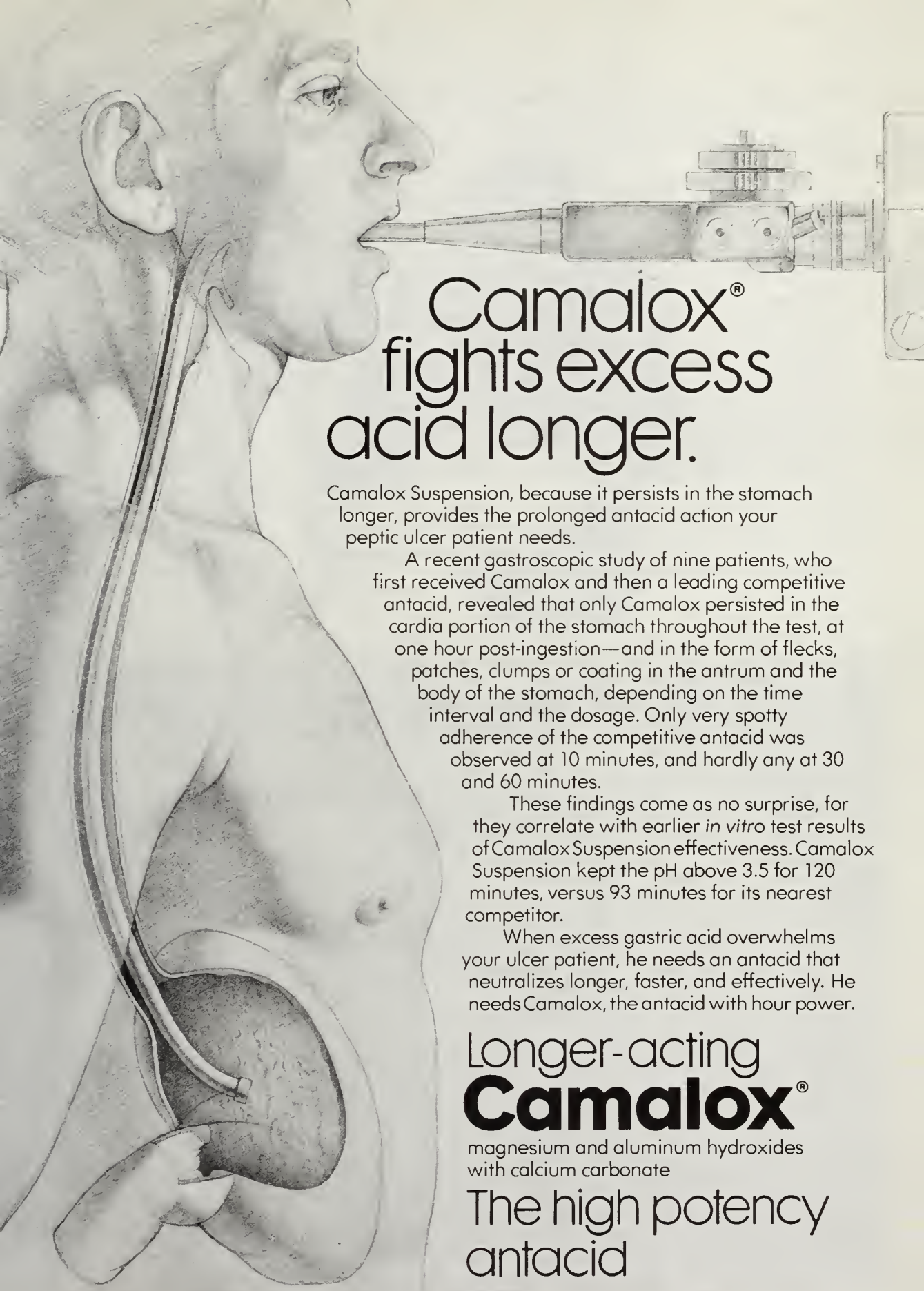
Case Western Reserve University, Pediatric Clinical Faculty, Fourth Annual Symposium, November 13-14. Topic: **Pediatrics — Prognosis and Prophylaxis.** Subjects will include the role of ambulatory pediatricians and the health team in primary care, and onrushing changes for physician and child in the delivery of pediatric care. Faculty: Evan Charney, M.D., Frederick Robbins, M.D., Jerome Liebman, M.D., Samuel Horwitz, M.D. Fee: none. For additional information, contact: S. S. Strassman, M.D., chairman, Pediatric Clinical Faculty, Rainbow Babies and Childrens Hospital, University Circle, Cleveland 44106.

March 1975

Core Curriculum: Pediatric Echocardiography — Sponsored by the American College of Cardiology, Cincinnati, March 17-20, 1975. For details, contact: American College of Cardiology, Department of Continuing Education Programs, 9650 Rockville Pike, Bethesda, Md. 20014.

May 1975

Microneurosurgery Symposium, Cincinnati Convention Center, May 29-31, 1975. Directors: Stewart B. Dunsker, M.D., and John M. Tew, M.D. Lectures, practical demonstrations and discussions will be provided by an international faculty. Special courses for nurses and surgical assistants also will be conducted. Sponsored by the Departments of Neurosurgery, The Christ and Good Samaritan Hospital, Frank H. Mayfield,, M.D., Director. For details, write: Ms. S. Stuckey, Coordinator, Microneurosurgery Symposium, 506 Oak St., Cincinnati 45219.



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Progress Reported in Cleveland Cystic Fibrosis Study

A recent article in the *American Review of Respiratory Disease* reports considerable progress made by a team of investigators at University Hospitals of Cleveland on the study of cystic fibrosis, particularly in regard to the relationship of pseudomonas as a cause of CF deaths.

Leading investigators are Dr. Bernard Boxerbaum, associate professor of pediatrics at Case Western Reserve University School of Medicine and associate pediatrician at the hospital, and Dr. LeRoy Matthews, director of pediatrics at the school and hospital.

Children suffering from CF are brought to the Cystic Fibrosis Institute at Rainbow Babies and Childrens Hospital from all parts of the country and from other countries.

The research project is supported in part by a U.S. Public Health Service grant from the National Institute of Arthritis and Metabolic and Digestive Diseases and by a grant from the Health Fund of Greater Cleveland.

GLIMPSE INTO THE PAST

"An Old Country Doctor"

A historical profile by Bob Slade in the May 23, 1974 issue of *The Clermont Sun* features Dr. William Eberle Thompson, native of the village of Bethel and practitioner of long standing there.

He was born in 1835, the son of Dr. Daniel Webster Thompson who moved to Bethel from Danville, Ky., in 1823. The family boasted 12 country doctors.

Dr. Thompson was a graduate of the Cincinnati College of Physicians and Surgeons, was a member of the former Ohio State Medical Society and its successor, the Ohio State Medical Association.

The writer states that "many times he had to swim his horse across streams, holding his medicine kit high to keep it from being swept away. Sometimes he had to learn symptoms from a member of the patient's family on the opposite bank and then, by tying a rock to medicines, throw them across."

He continued regular practice to the age of 98 and after that continued to see a few patients.





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OSMA Executive Director Named to Board of American Society of Association Executives



Hart F. Page
OSMA Executive Director

Hart F. Page, Executive Director, Ohio State Medical Association, Columbus, on August 6 was elected to serve as Director of his professional society, the American Society of Association Executives.

The election was held at the Annual Convention and Exposition of the American Society of Association Executives at the New York Hilton.

ASAE has a membership of 5,300 executives who manage leading trade, professional, industrial, and technical associations in the United States and Canada. Their organizations in turn represent more than 28 million members.

Mr. Page has been with the Ohio State Medical Association since 1946 in various positions. He has been Assistant Director of Public Relations and News Editor, Director of Public Relations and Assistant Executive Secretary, and presently serves as Executive Director.

Mr. Page is Chairman of the Education Committee of the American Association of Medical Society Executives. From 1972-74 he was a member of the Executive Committee of Medical Advances Institute. He has been appointed to the AAMSE Advisory Committee to the AMA Executive Vice-President. He is a former President of the Ohio Trade Association Executives.

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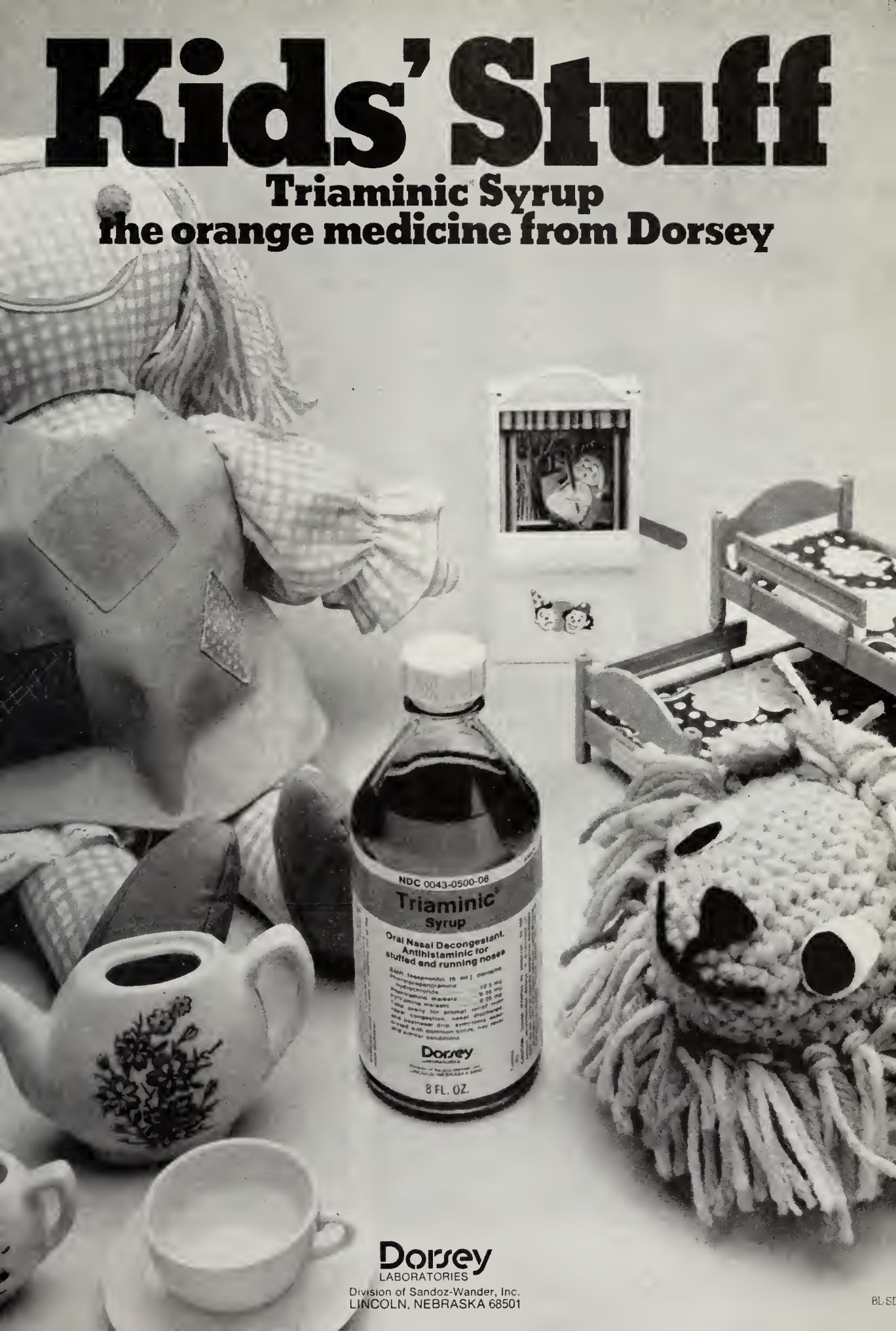


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IRS Revises Ruling Concerning Deductible Travel Expenses

The Internal Revenue Service has issued a revised ruling concerning the deductibility of expenses associated with traveling professional seminars, based on a Tax Court case.

In the ruling, the following references are cited and the brief as quoted given:

(Par. 6707) Rev. Rul. 74-292, I.R.B. 1974-25. 9. (Code Sec. 162. Also Code Sec. 262).

"Travel expenses: Doctor attending professional seminars abroad. Travel expenses incurred by a doctor on a trip which combined vacation travel abroad with attendance at brief professional seminars in each of the countries visited are not deductible business expenses under section 162 of the Code but are nondeductible personal expenses under section 262. Back references: Par. 1350.083 and 1350.11."

In its ruling, the IRS, referring to the case before the Tax Court, in part said: . . . "a doctor took a trip to several foreign countries. The trip was arranged by a medical association and travel arrangements were handled by a travel agency. The object and design of the trip was to combine travel to faraway cities with five medical seminars (each of one hour's duration) to be held at tourist hotels. No part of the cost of the trip was allocated by the travel agency to the seminars. The taxpayer attended all five seminars. The United States Tax Court stated that the trip was primarily for pleasure and the fact that a few hours were spent at brief medical seminars did not convert what was in all other respects a vacation into a business trip. The Court therefore held that since the cost of the trip was not incurred in any activity related to the taxpayer's trade or business no portion of such cost was deductible."

Dr. Walter K. Chess, of New Concord, has been named to the Board of Trustees of Muskingum College. He is a 1943 graduate of the college and received his medical degree from Western Reserve University in 1946.

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CONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

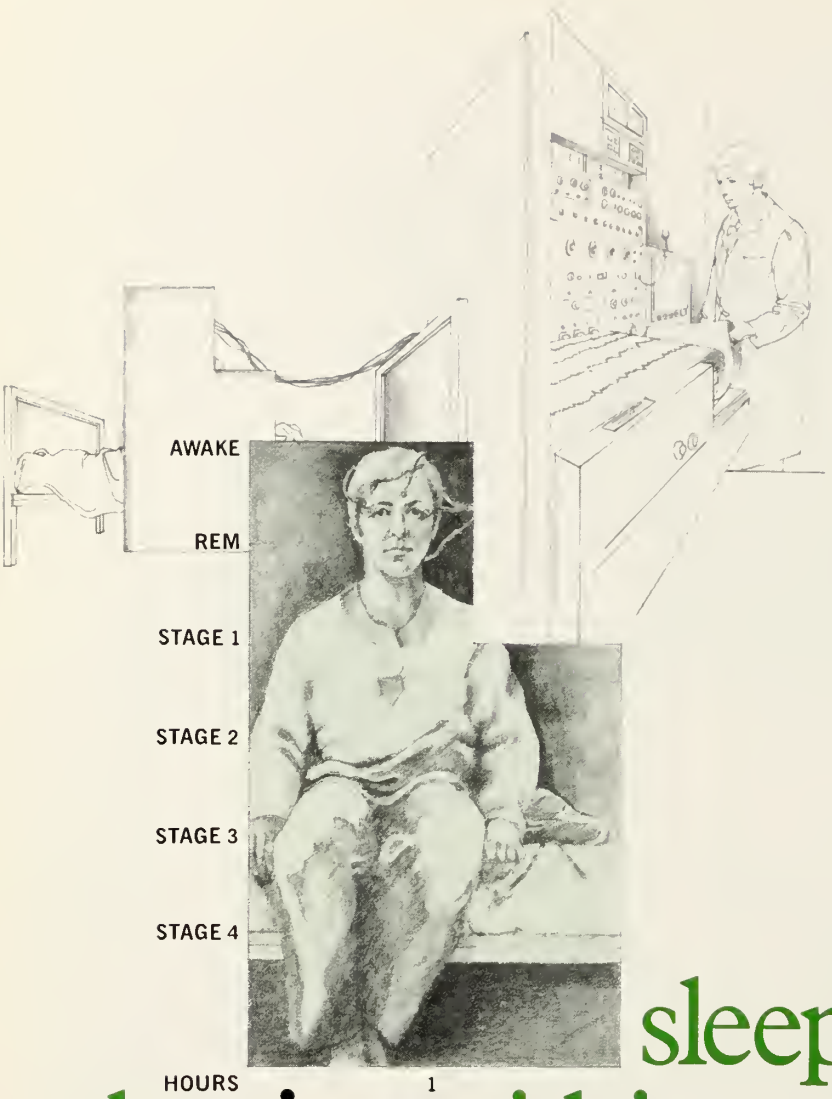
PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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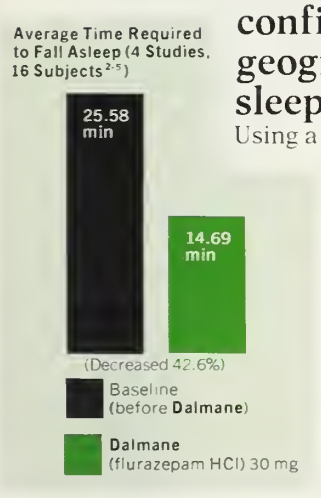
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confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

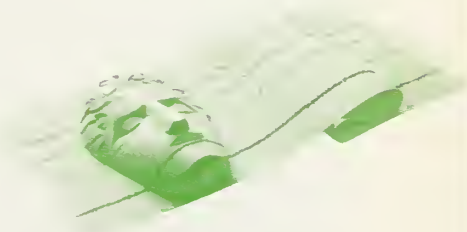
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

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Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry* 23:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Gastric Polypectomy

Case Report of Removal Via the Fiberoptic Endoscope

Philip Edlin, M.D.

SINCE ITS INTRODUCTION in 1963, fiberoptic endoscopy has shown itself to be a most helpful aid in diagnosis of diseases of the upper gastrointestinal tract. During the past three years, new instruments and technics have allowed careful inspection of the entire colon by the colonoscope as well. With skill, attention to details, and experience, snare-cautery technics through the fiber colonoscope have proved successful in removing polyps from the colon with relative safety and minimal distress for the patient.

Several workers have described a small number of patients in whom this technic has been used in removing polyps from the stomach. In the following patient, two gastric polyps were removed at one time through a fiberoptic endoscope.

Case Report

A 67-year-old white man was admitted to Cincinnati Deaconess Hospital because of mental confusion, loss of appetite, and jaundice of two weeks' duration. He had ingested large amounts of alcohol for many years, up to the time of this hospital admission. Two years before, hospital study revealed clinical and laboratory evidence of cirrhosis and hypothyroidism. At age 51 years, he suffered a myocardial infarction followed by uncomplicated recovery. These conditions improved with medical management, but he then became extremely erratic in following his treatment program.

Physical examination on admission revealed a well-developed and nourished man who was drowsy and confused. Sclerae and skin were icteric. The facies of hypothyroidism was apparent. Results of heart and lung examinations were normal. The abdomen showed a firm, smooth, sharp, nontender liver edge three finger breadths below the right costal margin in the midclavicular line. There was no bruit or rub over the liver. The spleen was not enlarged and there was no ascites.

Pertinent laboratory data included normal complete blood count, serology for syphilis, blood urea nitrogen, and blood glucose. Urine specimens were positive for bile. Serum bilirubin was 14.1 mg per 100 ml total and 6.8 mg per 100 ml indirect. Findings from hepatocellular function tests and serum enzymes were markedly abnormal. Thyroid function tests showed decreased function. Chest x-ray films showed minimal cardiomegaly with left ventricular preponderance. Upper gastrointestinal series showed a suggestion of esophageal varices, but the stomach and duodenum appeared to be normal. Intravenous cholangiography exhibited no visualization of gallbladder or ductal system. Electrocardiogram showed nonspecific ST and T wave abnormalities.

Hospital Course

The patient was treated with intravenous fluids, electrolytes, and vitamins and was then given a good general diet and oral thyroid extract. There was good laboratory and clinical response, although his total serum bilirubin remained at 4.6 mg per 100 ml. On October 3, 1973, upper gastrointestinal endoscopy was performed with the Olympus GIF instrument. Several small varices were found in the distal esophagus. In the antrum, a polyp with rather narrow base was seen. A second polyp was seen adjacent to the pyloric sphincter. On October 9, 1973, the patient was given 25 mg of meperidine hydrochloride (Dem-

Dr. Edlin, Cincinnati, is a member of the Staffs of Cincinnati Jewish, Deaconess, Bethesda, and Providence Hospitals; and Associate Professor, Department of Medicine, University of Cincinnati College of Medicine.

Submitted January 24, 1974.

erol) and 5 mg of diazepam (Valium) intravenously, and the Olympus endoscope was again passed into the stomach. The Cameron-Miller snare, designed for polypectomy through the fiber colonoscope, was passed through the biopsy channel and carefully placed around the base of the antral polyp (Fig. 1). With blended coagulation and cutting current from an ACMITRON® fulgurating unit, the polyp was removed, leaving a white area at the point of cauterization (Fig. 2). There was no bleeding. The snare was removed, and the polyp was grasped by a biopsy forceps and removed with the endoscope. Because the patient seemed quite relaxed and comfortable, the gastroscope was reintroduced, the polyp near the pylorus was encircled and removed as described for the first one, also with no evidence of bleeding. The first tumor measured about 2 cm, the second about 1 cm in diameter; both were benign on microscopic study. The patient was drowsy but awake during the procedure and described no pain or other sensation during cauterization. Two hours later he renewed his bland diet without incident.

Discussion

Removing gastric polyps efficiently and safely without abdominal surgery is obviously desirable in any patient. When the patient has serious medical problems, which greatly increase the risk of major surgery, this advantage becomes multiplied. Such was the case in the patient described. There was no pain during polypectomy, no bleeding or other complication following it. He experienced no aggravation of his other medical problems.

Tsuneoka and Uchida[1] reported the first gastric polypectomy in 1969. Since then several workers have reported similar success, each describing a single case or a small series.[2-8] These experiences indicate that gastric polypectomy through the fiber endoscope is feasible and safe. Only when larger series are reported, however, will the true incidence of complications, such as bleeding and perforation, be known.

Debate continues about the precancerous potential of gastric polyps. Tomasulo,[9] Ming and Goldman,[10] and others believe this potential does exist, while Monaco[11] does not. Certainly the opportunity to excise and section the entire polyp increases the chance of finding malignant change, when present, compared with multiple superficial biopsies.

A lesser but nonetheless significant advantage of endoscopic polypectomy, is found in the decreased financial cost and hospital bed usage when compared with major abdominal surgery.

Summary

Two polyps were safely removed from the stomach of a patient through a fiberoptic endoscope. The patient was a 67-year-old man who had hypothyroidism, coronary artery disease, and was mildly jaundiced from cirrhosis. Electrocautery was used through a wire snare loop as is used for colon polypectomy.

Thus far only a small number of such procedures has been published. But the excellent results certainly warrant further trial. If further experience continues to show similar success and safety, then properly selected patients can be spared the morbidity, mortality, and expense of



Fig. 1. Cautery snare loop lassoing antral polyp.



Fig. 2. After cauterization, polyp in grasp of biopsy forceps. Note clean base of polyp site.

major surgery. The lessened usage of hospital space and services is another desirable result.

Addendum

Since submission of this article, gastric polypectomy has been performed in two additional patients with similar success.

Acknowledgment: Appreciation is expressed to Dr. Paul Geiss, the patient's primary physician; to Dr. Antonio Marquez, surgeon, who participated in the procedure; and to Dr. Benjamin H. Sullivan of the Cleveland Clinic, for his advice and encouragement.

Generic and Trade Names of Drugs
Meperidine hydrochloride—Demerol (Winthrop Laboratories)
Diazepam—Valium (Roche Laboratories)

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Rectal bleeding in children—

is quite a different problem from that encountered in the adult. Meckel's diverticulum is the usual cause of massive bleeding although polyps and intussusception are two other relatively common entities that must be considered. The value of the newer diagnostic modalities (endoscopy and angiograph) has not as yet been fully assessed in this age group. Laparotomy in the presence of persistent rectal bleeding in the child remains a reasonable approach since the likelihood of finding a surgically remedial lesion is high. — Frank G. Moody, M.D., Salt Lake City: *The New England Journal of Medicine,* 290:839-841, 1974.

Cryptococcosis of Bone
Case Report

Miguel A. Pedraza, M.D.

CRYPTOCOCCOSIS is recognized as chronic fungal disease having special predilection for the lungs or the central nervous system. Bone involvement is infrequent. The first case of osseus cryptococcosis with systemic involvement was reported by Busse[1] in 1894, while the first case of cryptococcosis involving bone alone was reported by Brewer and Wood[2] in 1908.

Case Report

This 73-year-old Negro woman had difficulty with her left thigh with painful swelling and in-

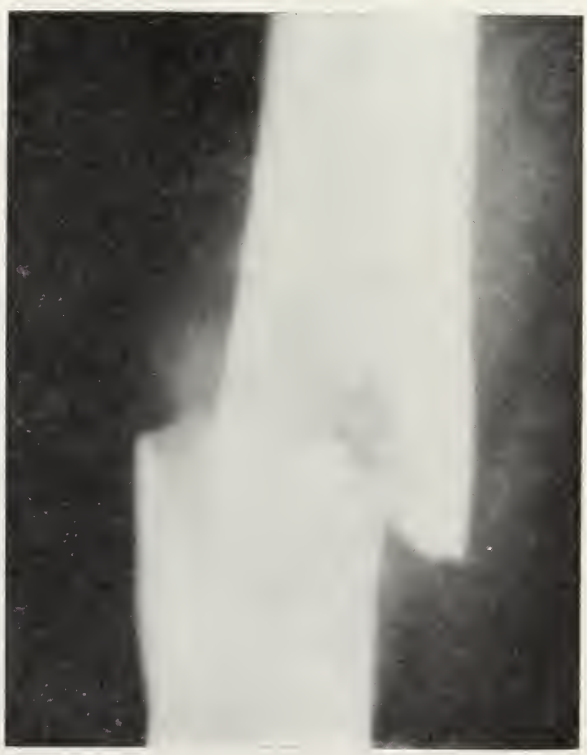


Fig. 1. X-ray film of left femur shows a pathologic fracture, apparently in vicinity of preexisting cyst or abscess.

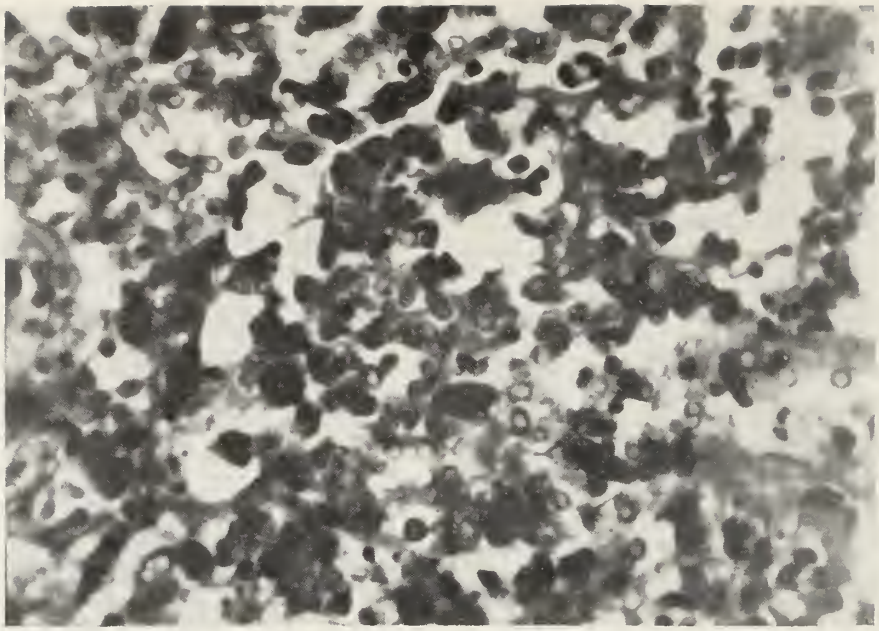


FIG. 2. Photomicrograph showing granulation tissue containing many cryptococci, each surrounded by a clear halo.

ability to walk of three month's duration. Two weeks before admission, the left thigh region began draining spontaneously. X-ray film of the left lower extremity revealed a pathologic fracture, apparently in the vicinity of a preexisting cyst or abscess (Fig. 1). Chest roentgenogram showed increase of the hilar markings.

Laboratory Examinations: Urinalysis was unremarkable. The hemoglobin level was 11.6 gm per 100 ml; hematocrit value 35.4 percent; white blood cell count (WBC) was 5600 per cu mm with 78 percent segmented neutrophils, stabs 8 percent, lymphocytes 8 percent, monocytes 5 percent. The fasting blood sugar in several determinations ranged from 115 to 290 per 100 ml. The serum electrolytes were normal. The blood urea nitrogen (BUN) level was 27 mg per 100 ml. The creatinine level was 2.5 mg per 100 ml.

Two days after admission, open reduction and fixation of the fracture was performed and multiple biopsies of bone and soft tissue were taken. A culture was obtained. Microscopic examination of this material showed multiple noncaseating granulomata surrounding a cystic cavity with numerous multinucleated giant cells (Fig. 2). The lesion contained numerous spherical-to-ovoid, budding, yeast-like organisms (Fig. 3). Each organism was surrounded by a halo and stained with periodic acid-Schiff and mucicarmine stains. Cultures obtained at surgery grew fungi at 37 C in

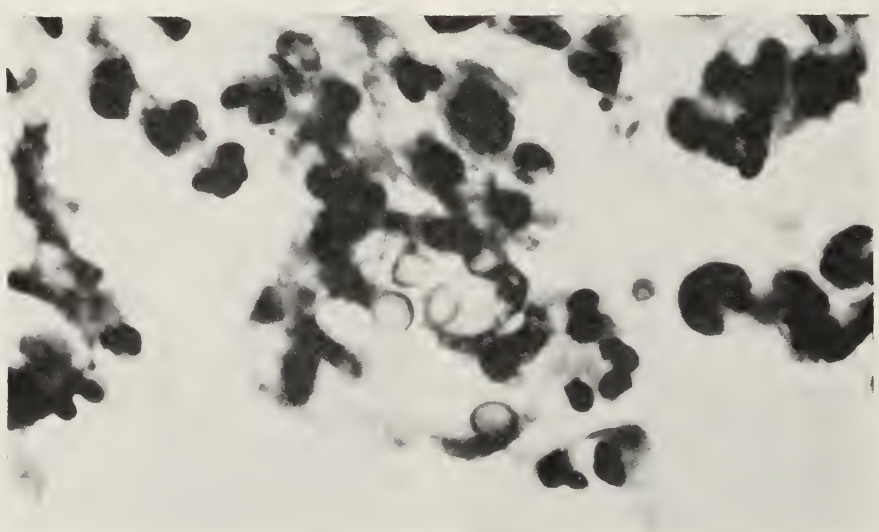


FIG. 3. Multinucleated giant cell containing several fungi.

Cases of Localized Osseous Involvement by Cryptococcosis

	Author	Year	Location
1.	Brewer and Wood	1908	Spinous process of thoracic and lumbar vertebrae
2.	Carter, Hessel, and Holtzwart	1934	Knee
3.	Ducuing, Bassal, and Miletzky	1937	Orbit
4.	Dienst	1938	Rib
5.	Jesse	1947	Inferior ramus of pubic bone
6.	Fisher	1950	Ilium
7.	Leopold	1953	Talus, wrist
8.	Bubb	1955	Femur
9.	Gorling and Gilmer	1956	Radius, clavicle
10.	Heller, McLean, and Campbell	1957	Iliac crest, radius
11.	Bernard and Owens	1960	Pedicle of thoracic vertebra
12.	Durie and MacDonald	1961	Tibia
13.	Allcock	1961	Metatarsal (4th) radius
14.	Morris and Wolinsky	1965	12th rib, transverse process of lumbar vertebra
15.	Reeves	1967	Parietal bone
16.	Sonck	1967	Rib
17.	Kuaty and Lewis	1968	Rib
18.	Cowen	1969	Ileum
19.	Davey and Ross	1969	Tibia
20.	Ong and Prathays	1970	Sternum
21.	Pedraza	1974	Femur

blood agar and Sabouraud agar. Smears of the mucoid cream colonies stained with India ink showed budding cells with large capsules. The urease reaction was positive.

The patient was considered to have osseus cryptococcosis, and a course of amphotericin B was given intravenously. A total dose of 975 mg was given and some toxic effects were noted as evidenced by a rise of blood urea to 95 mg per 100 ml and of creatinine to 3.7 mg per 100 ml with decrease of hemoglobin to 8.7 gm per 100 ml. The patient recovered well from the toxic effect. On the day prior to discharge, the blood urea level was 29 mg per 100 ml and her hemoglobin 11.6 gm per 100 ml with a hematocrit reading of 35.2 percent. After surgery, sputum cultures were obtained. These failed to grow any fungi. Chest x-ray films were read as negative for parenchymal involvement. Roentgenograms taken approximately 20 days after discharge show increased amount of healing at the fracture site and some obliteration of the cystic cavity. The patient is ambulatory on a walker, and she has full range of motion of her hip and knee with no recurrent swelling, pain or drainage at the site of the fracture.

Discussion

Disseminated cryptococcosis usually involves the central nervous system. Cryptococcosis with bone involvement resulting from hematogenous dissemination is comparatively rare, with a predilection for metaphyses of long bones, cranial bones, and vertebrae.[3]

In a review of the literature, we found approximately 50 cases of osseous cryptococcosis but only 21 were confined to bone. Of these, 12 had solitary osteolytic lesions while the rest had multiple foci of infection.[4] (See table.) The bony lesions caused by *Cryptococcus neoformans* are usually osteolytic with slight periosteal reaction.[5] Cryptococcosis has been reported associated with malignant lesions of the reticuloendothelial system,[6,7] lupus erythematosus, tuberculosis, diabetes,[8] sarcoid,[9,10] and in patients receiving steroids, broad spectrum antibiotics, or antimetabolites.

It appears that in localized osseus involvement in cryptococcosis the prognosis is favorable as long as the disease is confined to bone. It is suggested that the prognosis in localized bone disease is good, because it occurs mainly in individuals who are relatively fit or who have acquired a natural resistance to combat dissemination of the disease.[4]

Our patient was unusual in that she had no evidence of pulmonary lesions and her symptoms of pain, swelling, and draining were suggestive of chronic osteomyelitis. Subsequent sputum cultures were negative for cryptococcus. There was no evidence of parenchymal involvement on chest roentgenogram. She did have diabetes mellitus. The importance of prompt administration of amphotericin B, as a specific antifungal antibiotic, as an adjunct to surgery is readily apparent.

Summary

Bone lesions caused by *Cryptococcus neoformans* in the absence of a disseminated disease are

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Submitted January 31, 1974.

uncommon. A case of a solitary osseus lesion involving the femur is described, and a brief review of skeletal involvement in cryptococcosis is discussed.

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Hair-Spray Preparations—

Acute exposures (20 seconds) to hair-spray preparations A, B, and C caused significant decreases of maximum expiratory flow rates at low lung volumes in healthy men and women. Peak expiratory flow rates were reduced slightly after hair spray A only. The decreases were more pronounced on partial than on maximal expiratory flow-volume curves. On the partial curves, flow at mid-vital capacity decreased on the average 22 percent immediately after exposure to spray A (16 subjects), 21 percent after spray B (16 subjects), 29 percent after spray C (nine subjects), and 4 percent after placebo spray. These changes suggest that hair sprays cause acute, reversible narrowing of small airways. The chemical nature of the active ingredient (or ingredients) in hair sprays is not known; their mode of action may involve histamine release from lung tissue or a direct effect on airway smooth muscle, or both. Controlled inhalation studies in man should be required as part of the toxicologic evaluation of consumer products that may pose inhalation hazards.—Eugenija Zuskin, M.D., and Arend Bouhuys, Ph.D., New Haven: *The New England Journal of Medicine,* 290:660-663, 1974.

FROM THE AMA

New Society Will Boost Voluntarism by Physicians

Boosting voluntary health care service by American physicians both at home and abroad is the objective of a new organization formed this summer, Association of American Volunteer Physicians (AAVP).

Nucleus of AAVP is a group of several hundred American doctors who served brief volunteer tours in Vietnam, treating civilians in hospitals. They were participants in the American Medical Association's Volunteer Physicians for Vietnam program.

The Vietnam veterans formed the new society at a meeting in June in Chicago in conjunction with the AMA annual convention.

Among the stated goals of AAVP will be to participate, upon request, in cooperative health programs throughout the world, working in concert with the National Council for International Health, and a primary objective will be to encourage voluntarism in medical programs at home and abroad.

AAVP will maintain liaison with various organizations utilizing physicians volunteers abroad and will assist in professional and technical services. Its members will contribute to continuing education programs abroad, and will be available for professional service in national and international disasters.

Officers of AAVP are Lawrence A. Smookler, M.D., of San Francisco, president; Peter A. Nathan, M.D., of Portland, Ore., president elect; Albert B. Hagedorn, M.D., of Rochester, Minn., vice president; James F. Gerrits, M.D., of St. Clair, Mich., secretary-treasurer, and Charles R. Bowers, M.D., of Anderson, Ind., John V. Connolly, M.D., of Galveston, Texas, and Victor S. Falk, M.D., of Edgerton, Wis., councilors.

AAVP membership will be open to physicians who have served overseas with voluntary organizations and agencies, including those who participated in the AMA program in Vietnam.

Further information on the new organization is available through Dr. James F. Gerrits, M.D., secretary-treasurer, Post Office Box 107, Marysville, Mich. 48040.

A new film entitled "Out of Left Field" deals with integrating visually handicapped youths into sighted activities. "Not Without Sight" is another film defining visual impairment. Both films are for lay audiences. These are some of the aids available from the American Foundation for the Blind, 15 West 16th Street, New York, N.Y. 10011.

Maternal Mortality Report for Ohio — 1971

By the OSMA Committee on Maternal Health*

YOUR COMMITTEE ON Maternal Health is pleased to publish this SEVENTEENTH consecutive Annual Report for the year 1971. Apologies for its delay in appearance are respectfully tendered; the tardiness involving a transition to computer-processing is explained herein. The report is published in compliance with a directive creating the Committee, establishing its functions, and subsequent follow-up action taken by The OSMA Council, January 16, 1954.[1]

Divided into five sections, the first part outlines activities of your Committee since its last report to Council on January 28, 1973.[2]

The second section describes several Committee projects which represent developments related to its assigned functions, while the third portion contains a detailed statistical summary for 1971 from the Ohio Study. All maternal deaths occurring in 88 counties are covered, regardless of whether the patient died at home or in a hospital. Part four contains a summary and discussion of the data; the last division bears *recommendations* from your Committee, based upon its experiences with "Maternal Health in Ohio."

Activities

The Committee on Maternal Health consists of 21 members who represent the Association's 11 Councilor Districts geographically. Professionally, they provide talent from the family physician as well as the specialties, eg, obstetrics and gynecology, anesthesiology, internal medicine, and pathology.

Categorically, this report covers a period of approximately 20 months, beginning January 1973 and ending September 1974.

Three meetings were held by the Committee: the 57th at Granville, Ohio, January 20-21, 1973, the 58th in Columbus April 29, 1973, and the 59th at Granville, January 19-20, 1974. All three meetings were declared highly successful, and accomplished conclusive discussions on pertinent subjects ranging from revision of the Maternity Hospital Licensure Regulations to policies and opinions on rubella (vaccination) immunization, and routine gonorrheal tests, to an official statement on *elective abortion*. The latter policy was officially adopted in May 1973 by the OSMA House of Delegates.

During the period of 20 months, the Committee studied and classified 114 maternal cases, using "Guiding Principles"[3] as a standard.

Late in 1973, the Committee regretted to lose its dedicated and efficient Secretary, Mr. Herbert Gillen, as he was assigned to a highly responsible position with Medical Advances Institute. However, members were grateful to learn that (Mrs.) Gail Dodson, a competent staff member of many years, was assigned in his place as Committee Secretary. Indeed, we did welcome her!

Two members of the Committee (Ramsayer and Ruppersberg) continued to serve on the Ohio State Medical Board; unfortunately, after a prolonged term of service, Dr. Ramsayer was not reappointed by the Governor when his term expired in April, 1974. As a matter of note, the State Medical Board has examined and licensed 12 registered-nurse midwives since January 1973.

Fortunately, the Chairman was able to attend three two-week OSMA, overseas seminar programs, in the South Pacific (April 1973), in Europe (August 1973), and in South America (March 1974).

Projects

Since its incipiency in September 1956,[4] the Committee continues to publish articles and reports in *The Journal*. To date, 131 articles have appeared in its "Maternal Health in Ohio" column.

As previously reported, the Committee envisions the use of voluminous statistics and data contained in the 1,500 or more cases on file, to provide a continuous educational program in future years. Facts and data on every case have been punch-transcribed onto an IBM card. To make the data more readily available for numerous education and information programs,

*A continuous statewide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

members voted in 1972 to pursue measures for re-adapting from the IBM system to the computer. Time and money were required. A grant of $1400 was obtained from a benefactor source, without cost to the OSMA, and for the past year, the Chairman has worked with the statistical division, Ohio Medical Indemnity, Inc., laboring through a tedious, but worth-while program. Test programs are being devised currently to prove the veracity of the transcriptions. Soon the computer will facilitate the acquisition of prescribed data, originally compiled through laborious efforts of Committee members and many others. Due to this year of "special schedules" and allied projects, this *seventeenth* annual report was delayed.

The Committee prepared and displayed two exhibits, "Maternal Deaths from Pulmonary Emboli" (May 1973, OSMA Annual Meeting, Columbus) and "Cycles of Life and Health" (May 1974, OSMA Annual Meeting, Cleveland). Both were well received by physicians and guests.

As in past years, Committee members maintain close liaison with the well-established county maternal death studies. *Six* of these continue to operate on an annual basis, in Cleveland, Columbus, Cincinnati, Dayton, Toledo, and Akron. Operated principally by local obstetric-gynecologic societies they are coordinated with the State Study.

Statistics from the Ohio Maternal Mortality Study are published below. Nomenclature and terminology used in the study have been employed since their adoption in 1954. They follow closely those prescribed in *The International Classification,* and definitions recommended by the AMA and the ACOG.

Ohio Maternal Mortality Study
Statistics for 1971

Total Live Births in Ohio, 1971 189,919
(Total Cases in files, 17 years, 1955-1971) = 1608

Total Cases Studied (1971) 55
- Cases not studied due to lack of information 0
- Undetermined 0

Maternal Deaths (Classified) 42
- Non-white 13
- White 29

Age:
- Teens 4
- 20's 24
- 30's 13
- 40's 1

Parity:
- Primigravidae 10
- Multiparae 29
- Unknown 3

Place of Death:
- Hospital 37
- Home 4
- Other 1

Type of Delivery:
- Not recorded 0
- Operative 27
- Nonoperative (spontaneous) 9
- Not delivered 6

Route of Delivery:
- Not recorded 0
- Vaginal 22
- Cesarean 14
  - (antemortem) 14
  - *(postmortem) 0
- Laparotomy (ectopic preg.) 0
- *Not delivered 6

Case Classification (when death occurred):
- Not known 0
- Group I (fr. concept. to 20th wk.) .. 5
- Group II (fr. 20th wk. to 28th wk.) . 2
- Group III (fr. 28 wk. through term) 1
- Group IV (postabortal, postpartum) 34

Autopsies 32
(includes 6 coroners' cases)

Prenatal care (apparent from data sheets):
- None 6
- Unknown or not reported 2
- Adequate 24
- Inadequate 5
- Excluded (ectopic preg. and abortion) 5

Classification of preventability:
- Nonpreventable 16
- Preventable (avoidable factor) 26
  - Patient responsibility (P_1) 7
  - Personnel responsibility (P_2).. 12
  - Both P_1 and P_2 7
  - P_3 (Misc.) 0

Classification of Primary Causes of Death:

Hemorrhage 11
- Abortion, without sepsis 0
- Abruptio 0
- Afibrinogenemia 0
  - Abruptio 0
  - Am. fl. embolus 0
  - Dead fetus 0
  - Ruptured uterus 0
- Atony, uterine, postpartum 2
- Ectopic pregnancy (without sepsis) 5
- Laceration, extrauterine 0
- Placenta Praevia 0
- Retained Placenta 1
- Ruptured uterus (no afibrin) 2
- Other 1

High Risk Related: 1 Non-Related: 1

Infection 11
- Abortion, alleged "criminal" 3
- Abortion, septic, induced 1
- Up. resp. Inf. 1
- Peritonitis 3
- Pyelonephritis 1
- Septicemia (puerperal sepsis) 0
- Septicemia (other) 1
- Other 1

High Risk Related: 0 Non-Related: 1

Toxemia 1
- Acute yellow atrophy 0
- Hypertension, chronic (incl. hypertension with cerebrovascular hem.) 0
- Eclampsia 1
- Preeclampsia 0
- Puerperal toxemia, not specified 0

High Risk Related: 0, Non-Related: 0

Other 19
- Amniotic fl. emb. (no hemorrhage) 2
- Anesthesia 1
  - (general) 1
  - (regional) 0
- Cardiac disease 2
- Cerebrovascular hemorrhage (no tox.) 2
- Chorioepithelioma 1
- Liver disease 2
- Lower nephron-nephrosis 0
- Pulmonary edema 1
- Pulmonary embolus 8
- Renal disease, chronic, unspecified .. 0
- Other 0

High Risk Related: 4, Non-Related: 6

(Continued on Page 570)

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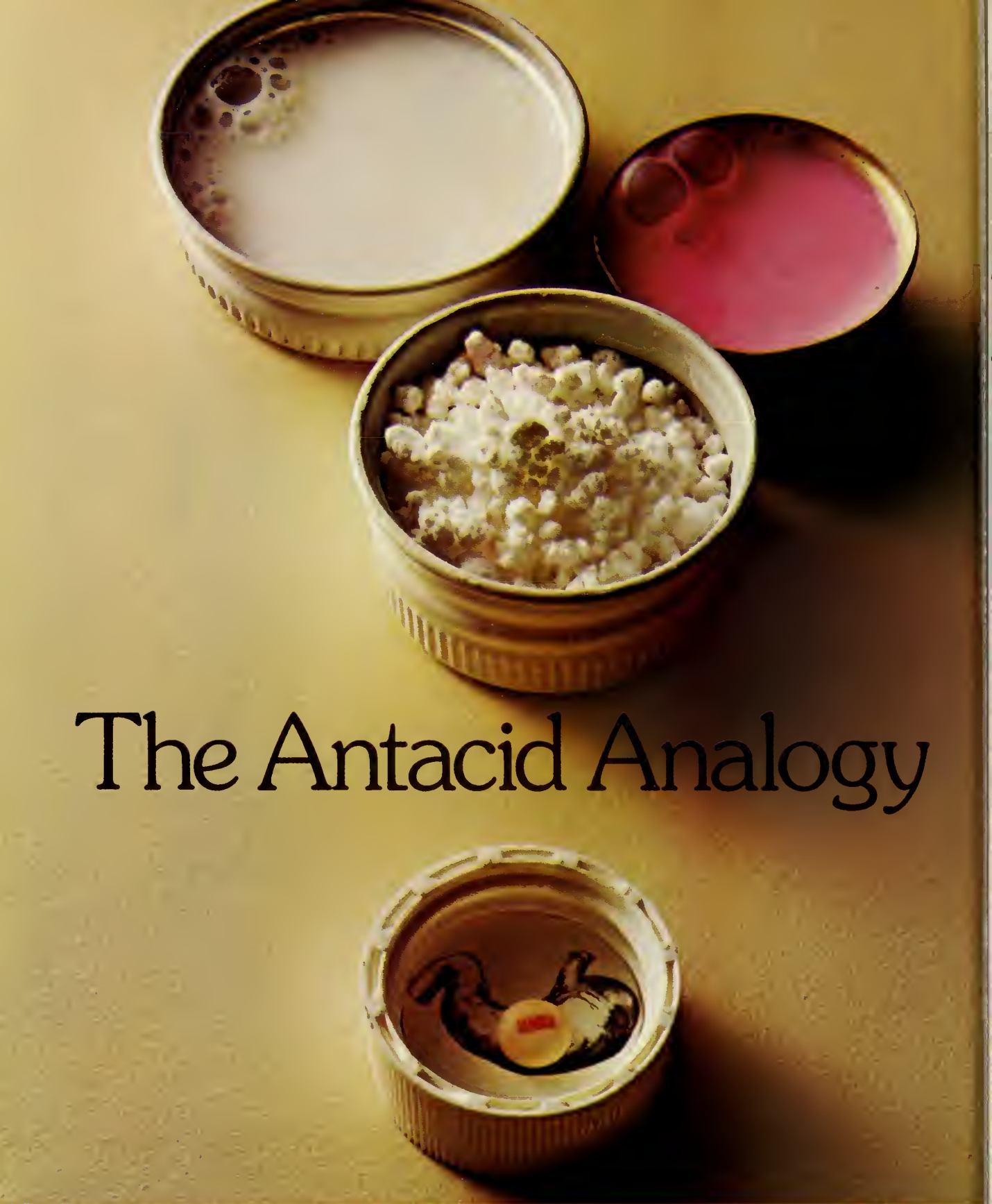


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Fever and possibly heat stroke may occur due to anhidrosis.

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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ccur as well as mydriasis and blurred vision. In addition the following dverse reactions have been reported: nervousness, drowsiness, dizziness, nsomnia, headache, loss of the sense of taste, nausea, vomiting, constipa-on, impotence and allergic dermatitis.

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The Role of the Detail Man

Opinion & Dialogue

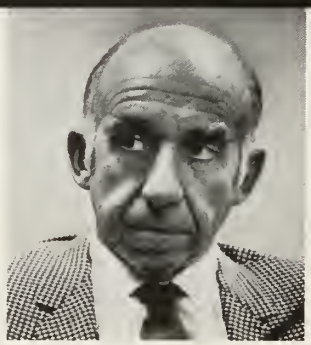


Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date inforrnation about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

During 1971 there were 189,919 live births in Ohio.[5] From this maternal mortality study, the Committee classified 42 maternal deaths for the year. The maternal mortality rate was 0.22 per 1000 live births, or 2.21 per 10,000 live births for 1971. This rate is slightly lower than the rate reported for 1970.[2] Furthermore, Ohio reported 2307 *stillbirths* (fetal deaths) during 1971, making the figure for *total births* 192,226.

Discussion

Our first observation reveals a decrease of 20,768 live births in Ohio from 1970 thru 1971.[2] Indeed, this seems to begin a downward turn in the previous trends reported. The maternal mortality rate for 1971 as calculated is slightly lower (2.21) than that reported for 1970 (2.30).

Six of the 42 patients died undelivered; four were teenagers, but none was under age 15 years. Autopsies were performed upon 75 percent of the patients; six were coroner's cases. Twenty-six of the 42 maternal deaths were voted *preventable* with 12 assessed *personnel* responsibility alone.

Hemorrhage and infection vie equally as leaders of primary causes of death; under "other causes," pulmonary embolism prevails. Among 42 maternal deaths, the Committee found 12 to be High Risk obstetric patients before pregnancy; of these, *five* had a cause of death *related* to the High Risk condition. One of these was due to hemorrhage, while four were under the "other causes" classification.

Recommendations

1. Once again, the Committee recommends that the Ohio Maternal Mortality Study with its educational facets be continued.

2. Council, Committee members, and the general medical profession should continue related efforts with the Ohio Department of Health toward the improvement of "Maternal Health in Ohio."

3. Liaison with local Health Department Registrars of Vital Statistics Bureaus should be improved; possible maternal and nonmaternal death cases can be *culled* at local levels and can assist in initial work-up of respective cases, by Committee members.

4. With the advent of improved technology in data processing of our cases, Council and Committee members are invited to expand the educational facets of our maternal health program in respective communities.

With sincere appreciation, the Chairman acknowledges the support of Committee members who discharged their duties effectively during the reported period. And on behalf of the Committee, its Chairman recognizes assistance of the Council, attending physicians, representatives of many county medical societies, the Ohio Department of Health, Ohio Coroner's Association, and many other individuals and agencies. Without their coordination and continuous support, this Maternal Mortality Study could not continue.

Respectfully submitted,

Anthony Ruppersberg, Jr., M.D.

Chairman, Committee on Maternal Health

Approved by The Council of The Ohio State Medical Association, July 28, 1974.

References

1. Maternal mortality study, statewide basis. *Ohio State Med J* 51:886-888, 1955.
2. OSMA Committee on Maternal Health: Maternal mortality report for Ohio — 1970. *Ohio State Med J* 69:202-204, 1973.
3. Guiding principles for obstetric care. *Ohio State Med J* 53:1328-1329, 1957 (revised 1963 and 1972, reprinted, not published).
4. OSMA Committee on Maternal Health: Maternal deaths due to hemorrhage. *Ohio State Med J* 52: 951-952, 1956.
5. Ohio Department of Health, Bureau of Vital Statistics. Special communication.

Cincinnati Medical College Dedication Scheduled

Dedication ceremonies for the massive new home for the University of Cincinnati College of Medicine are scheduled for October.

The tentative schedule follows:

Thursday, Oct. 10 — Afternoon reunion of former house staff members of Department of Medicine; 7 p.m. — Banquet officially opens the dedication events, at Hotel Netherland Hilton.

Friday, Oct. 11 — in Kresge Auditorium of new College of Medicine Bldg., 9 a.m. to 12 noon — scientific sessions devoted to *Medicine in 2000;* 2:30 p.m. formal dedication ceremony, open house, and tours.

Saturday, Oct. 12 — Continuation of open house and tours. Programs by Department of Psychiatry and Department of Surgery (meeting of Mont Reid Society)

A new Heart Association desk card giving guidelines in four distinct areas of hypertension drug treatment is available. "Outline of Recommended Antihypertensive Regimens for Groups with Varyingly Severe Hypertension as Indicated by Diastolic Pressure" (EM 633) may be ordered from the American Heart Association, Ohio Affiliate, 10 East Town Street, Columbus, Ohio 43215 or one of its Chapter Offices. They are located in Akron, Canton, Cincinnati, Cleveland, Columbus, Dayton, Toledo, and Youngstown.

Professional Activities



Proceedings of The Council

Meeting of July 27-28, 1974

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday and Sunday, July 27-28, 1974, at the OSMA Headquarters' office, 600 S. High Street, Columbus, Ohio.

Those present Saturday were: All members of The Council; Mr. James E. Pohlman, Columbus, OSMA Legal Counsel; Richard L. Meiling, M.D., Columbus, Chairman, Ohio Delegation to the AMA; Mr. Guy D. Beaumont, Jr., Columbus, Field Representative, AMA Public Affairs Division; Janis Trupovnieks, M.D., President of the Harrison County Medical Society; Mary King, Columbus, Representative of the Student AMA; and Messrs. Page, Edgar, Campbell, Rader, Houser, Holcomb, Mrs. Wisse, Mr. Moore and Mrs. Dodson, of the OSMA Staff.

Those present Sunday were: All members of The Council (with the exception of Drs. Lieber and Smithson); Mr. Pohlman, Mr. Beaumont; Anthony Ruppersberg, Jr., M.D., Columbus, Chairman of the OSMA Committee on Maternal Health; Jack E. Tetirick, M.D., Columbus; William A. Sodeman, M.D., Toledo; Mrs. King, and all members of the OSMA Staff with the exception of Mr. Clinger.

The meeting was called to order by President Henry.

The minutes of the meetings of March 8, 9 and 10; April 6, and May 16, 1974, were **approved.**

President Henry appointed, after consultation with the Council, the following members to the Ad Hoc Committee on Constitution and Bylaws Revision and Professionalism:

James C. McLarnan, Mt. Vernon, Chairman, District 10
Glenn B. Doan, Greenfield, District 1
A. Robert Davies, Troy, District 2
Alford C. Diller, Convoy, District 3
M. Brodie James, Toledo, District 4
Nicholas DePiero, Cleveland, District 5
John A. Karnoupakis, Cuyahoga Falls, District 6
Robert R. Johnson, Coshocton, District 7
Walter B. Devine, Zanesville, District 8
A. Burton Payne, Ironton, District 9
S. Baird Pfahl, Sandusky, District 11

The official announcement by R. Gordon Moore, Executive Editor of *The Ohio State Medical Journal,* of his projected retirement on October 15, 1974, was received with regret.

Membership

Mrs. Wisse presented membership statistics.

The Council voted to encourage county medical societies to change their Bylaws in order to encourage membership of interns and residents and to implement membership promotion among these candidates.

EXECUTIVE SESSION

Fiscal Matters

The Council was convened in Executive Session.

The June 29, 1974 minutes of the Auditing and Appropriations Committee were presented by Dr. Bates and **were approved** as read.

A motion by Dr. Bates, seconded by Dr.

Gaughan, to donate money to a convocation and symposium on health care sponsored by the Toledo Law Review failed of passage.

On a motion by Dr. Gaughan, seconded by Dr. Wells, the following resolution was adopted by the Council:

"RESOLVED, that the Ohio State Medical Association negotiate an unsecured loan in the amount of Three Hundred Thousand and 00/100 Dollars ($300,000.00) from the Huntington National Bank of Columbus and that James L. Henry, President, be authorized to execute for and on behalf of the Association a promissory note in the form attached hereto and to deliver the same to The Huntington National Bank of Columbus; that the action of the President in executing and delivering said note on July 25, 1974 be and the same is hereby ratified and confirmed; and

"BE IT FURTHER RESOLVED, that the proceeds of the aforesaid loan be used to reduce to Two Hundred Thousand and 00/100 Dollars ($200,000.00) the principal balance of a note in the amount of Five Hundred Thousand and 00/100 Dollars ($500,000.00) held by said Bank and secured by a mortgage on the headquarters building located at 600 South High Street, Columbus, Ohio, and which note and mortgage will be sold and assigned to The Huntington National Bank of Columbus, Trustee of Ohio State Medical Association Pension Fund pursuant to its take-out commitment dated April 10, 1973; and

"BE IT FURTHER RESOLVED, that all acts of, and by, the Council of Delegates, the officers of the Association, and the Building Committee prior to this date, in connection with the acquisition of the land, construction of the building and the construction loan and permanent loan to finance said construction, including without limitation the amendment of the Five Hundred Thousand and 00/100 Dollar ($500,000.00) note secured by a mortgage of said real estate, which amendment was dated April 20, 1973 and executed by James L. Henry as Treasurer of this Association, be and the same are hereby ratified, approved and confirmed in all respects."

Council voted to donate, on request of the Ohio Society, $50 to the election campaign of Laura Lockhart, who is a candidate for a national office (President-Elect) in the American Society of Medical Assistants.

The President was instructed to notify visitors to the Council, in advance, of the time schedule and time limits of their presentations.

The President was authorized to make available to the President of the OSMA Woman's Auxiliary such information on Council deliberations as appropriate.

The Council was reconvened in regular session.

Mr. Robert Holcomb, who began his employment as field representative of the OSMA this date was introduced and spoke briefly with regard to his previous experience.

American Medical Association

Dr. Meiling presented the report of Ohio's AMA Delegation regarding the June, 1974 meeting of the American Medical Association.

The delegation was authorized to proceed with the development of a resolution concerning the role of the Judicial Council in the AMA structure, for presentation at the Clinical Meeting of the AMA in December.

A "white paper" on Reports "P" and "Z" (A-74) of the Board of Trustees of the AMA at the 1974 AMA Annual Session was requested of Dr. Meiling for consideration by the Council.

The next meeting of Ohio's AMA Delegation with the Council was set for October 25, 1974.

The Council commended the chairman and the delegation for their diligence.

Dr. William A. Sodeman, of Toledo, addressed the Council concerning his interest in standing for election to the office of president-elect of the AMA.

The Council requested that Dr. Sodeman ask the President of the Pennsylvania State Medical Society to communicate with Dr. Henry concerning this proposal.

The minutes of the AMA delegation meeting, held May 14, 1974, were presented by Mr. Campbell and were accepted.

Annual Meeting

Reports on the 1974 Annual Meeting and plans for 1975 were presented by Mrs. Dodson.

The Council requested that the "Category One" continuing medical education accreditation for the annual meeting be obtained.

Requests from the Montgomery County Medical Society and from the Toledo Academy of Medicine that Dayton and Toledo be considered as sites for the OSMA Annual Meeting were referred to the Committee on Scientific Work for investigation and advice to the Council.

Section on Dermatology

The organization of a Section on Dermatology was approved by official action of the Council.

Student American Medical Association

A report from Ohio's Student Business Session was discussed by Mrs. Mary King and was accepted for information.

1974 Resolutions

The Council issued the following instructions with regard to implementation of 1974 resolutions and added the matter involving medical student membership and medical student vote in the OSMA House of Delegates:

Amended Substitute Resolution No. 3, Responsibility for Handling of Matters of Ethics — referred to Ad Hoc Committee on Bylaws Revision and Professionalism.

Substitute Resolution No. 4, Appointment of Members to Resolutions Committees — referred to Ad Hoc Committee on Bylaws Revision and Professionalism.

Amended Resolution No. 5, Dues Increase — referred to Comptroller for implementation.

Amended Resolution No. 6, Public Relations Levy — referred to OSMA Committee on Public Relations.

Substitute Resolution No. 9, Information and Education Serve Freedom — referred to Editor of the OSMAgram.

Resolution No. 10-74, Professionalism — referred to Ad Hoc Committee on Bylaws Revision and Professionalism.

Resolution No. 11, To Commend the Ohio Foundation for Medical Care — referred to Ohio Foundation for Medical Care.

Amended Resolution No. 12, Affiliate Membership — referred to Ad Hoc Committee on Bylaws Revision and Professionalism.

Amended Resolution No. 14, Governor's Task Force on Health Care — communication to Governor and referred to the Committee on Government Medical Care Programs.

Amended Resolution No. 15, Budget Publication — referred to Ad Hoc Committee on Bylaws Revision and Professionalism.

Amended Resolution No. 16, Compulsory Post Graduate Medical Education Program — referred to Commission on Education.

Amended Substitute Resolution No. 28, Repeal of P.L. 92-603 — referred to Department of Federal Legislation for drafting of amendments and referred to Ohio's Delegation to the AMA.

Amended Substitute Resolution No. 23, Peer Review — referred to Editor of the OSMAgram. Communication to county societies from the President of OSMA.

Substitute Resolution No. 34, MAI — refer to MAI through communication from the President.

Amended Substitute Resolution No. 35, Local Peer Review Systems — communication from OSMA President to MAI.

Amended Resolution No. 19, Preadmission Certification — referred to Editor of OSMAgram (mail copy of resolutions to MAI).

Amended Resolution No. 20, Standardized Insurance Form — referred to OSMA Committee on Insurance.

Resolution No. 36, Repeal of Prenatal Gonorrhea Testing — referred to Department of State Legislation.

Amended Resolution No. 37, Comprehensive Health Education in Ohio's Public Schools — referred to OSMA Committee on School Health.

Amended Resolution No. 39, National Health Insurance — referred to Ohio Delegation to the AMA and referred to Department of Federal Legislation.

Amended Resolution No. 40, Involvement of Allied Professional and Non-Professional Employers in Common Causes — referred to Ohio Delegation to the AMA; reiterates existing OSMA policies and programs.

Resolution No. 43, Sports Medicine Commendation — referred to Joint Advisory Committee on Sports Medicine of the OSMA/OHSAA.

Resolution No. 44, Assignment via "Healthcard" — referred to Ohio Delegation to the AMA. Resolution was introduced and passed at the June Annual Meeting of the AMA.

Amended Resolution No. 45, Out-Patient Diagnostic Procedures — referred to OMI Liaison Committee, HIC and Blue Cross.

Substitute Resolution No. 50, Bureau of Crippled Children's Services — referred to Department of State Legislation. Bill has been introduced and has passed the Ohio General Assembly.

Report on Resolution No. 3-73, Ethics of Charging Interest Rates — re-referred to Committee on Judicial and Professional Relations.

Report on Resolution No. 30-73, Ethical Status of Provider Agreement — referred to Committee on Judicial and Professional Relations.

Council referred matters of medical student membership in OSMA and medical student vote in the House of Delegates to the Ad Hoc Commit-

tee on Constitution and Bylaws Revision and Professionalism.

MAI

The Council recessed and a meeting of the members of MAI was convened by Dr. Oscar W. Clarke, for a discussion of the minutes of the MAI Board of Trustees meetings of May 8 and June 9, 1974, and of a proposal for the sale of the system.

Ohio Medical Indemnity, Inc.

Dr. Clarke reviewed the minutes of the Board of Directors meetings of April 17 and July 24, 1974, and of the OMI Executive Committee June 19, 1974.

He announced the expansion of OMI's usual, customary and reasonable group contract.

The report was accepted for information.

Ohio Foundation for Medical Care

Minutes of the meetings of the Board of Trustees of the Ohio Foundation for Medical Care held April 3, May 1, and June 5, 1974, were received for information.

Committee Reports

Committee on Maternal Health

Dr. Anthony Ruppersberg, Jr., Chairman, presented the 1971 Maternal Mortality Report for Ohio, by the OSMA Committee on Maternal Health, and it was **approved** for publication in *The Journal*. It was pointed out that the Committee is now in its 20th year of operation.

Committee on Prisons and Jails

The minutes of the April 23 and July 10 meetings of the Committee on Prisons and Jails were presented by Mr. Houser and were accepted for information.

Committee on Government Medical Care Programs

The minutes of the April 24 and July 17 meetings of the Committee on Government Medical Care Programs were presented by Mr. Houser.

The Council **approved** a proposed letter from the President to the Director of Welfare concerning reductions in fees for Obstetricians and Gynecologists.

In the Government Medical Care Programs Committee minutes of July 17 —

The Council **approved** implementation of the following proposal: "That the file regarding Civil Rights agreements between OSMA, ODPW, and HEW be referred to legal counsel in an attempt to determine if the agreement made in 1966 was and is a valid agreement and if legal counsel determines that said agreement is in his opinion a valid agreement, let Council authorize legal counsel to pursue the issue with the ODPW and/or the courts as indicated."

A proposal on reference of problems of Medicaid to a particular committee was noted, but not approved. Instead, the President was authorized to communicate with the chairman involved in order to achieve an understanding and clarification of issues to be referred and the appropriate committee.

A policy statement endorsing the principles of the Early Periodic Screening, Diagnosis and Treatment Program contained in the EPSDT national program amendment to Title XIX of the Social Security Act was re-referred to the committee.

A motion by Dr. Pichette, asking for a study with regard to the feasibility of adoption of a policy on all screening programs, was adopted by the Council and was referred to the Ad Hoc Committee on Constitution and Bylaws Revision and Professionalism.

The minutes, as a whole, were **accepted as amended.**

Committee on Health Care of the Poor

The minutes of the May 5 meeting of the Committee on Health Care of the Poor was presented by Mr. Houser.

A proposed symposium on the Early Periodic Screening, Diagnosis and Treatment Program was discussed. It was requested that additional information be obtained and a mail poll of the Council be conducted if appropriate.

The President was instructed to communicate with the Ohio Welfare Director, seeking review of the "Ten Day Visit Limitation" policy of the Department of Welfare.

The President was directed to communicate with the Ohio Director of Welfare, protesting a communication from the Department's Office of Management Operations, which urges all providers to accept Medicare assignments for Welfare recipients covering the deductible and coinsurance part of Medical claims.

Commission on Medical Education

The Commission on Medical Education minutes of May 22 were presented by Mr. Edgar.

The Council **approved** the inclusion of accreditation of osteopathic continuing medical education facilities, on request, in the OSMA accreditation system.

The report **was approved.**

Joint Auditing and Appropriations/Membership and Planning Committees

The minutes of a joint meeting of the Auditing and Appropriations Committee and the Membership and Planning Committee, on June 29 were presented by Mr. Page and **were approved.**

Committee on Organ Transplant

The minutes of the Committee on Organ Transplant meeting on July 9 were presented by Mr. Rader and **were approved.** The report included a proposal for consideration of a state-wide, central registry for potential anatomical donors.

Committee on Health Manpower

The Council reviewed a letter from William E. Sovik, M.D., Chairman of the Committee on Health Manpower, and adopted the following definition of the "physician's assistant":

"The physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant, and shall have successfully completed a proficiency examination developed and presented by the National Board of Medical Examiners."

Also **approved** was the Committee's recommendation that OSMA publicize and make available to members copies of the AMA publication "Employment and Use of Physicians Assistants—A Guide For the Physician."

Committee on Medicine and Religion

Minutes of the Committee on Medicine and Religion meeting held April 10, 1974, were **accepted for information.**

Council Fee Review Committee

Minutes of the Council Fee Review Committee meeting held July 26 were presented by Mr. Campbell and the report **was approved.**

At the request of Dr. Morgan, Council authorized the referral to the Council Fee Review Committee a patient complaint from his district.

Blue Cross Request

A request from Blue Cross of Central Ohio regarding the Mercy Memorial Hospital in Urbana was referred to MAI for technical advice and review.

Federal Legislation

Mr. Edgar reported on Federal Legislation. He reported that medicine was particularly concerned over a bill being pushed strongly by Senator Kennedy, S. 3585—Health Professional Education Assistance Act of 1974—which would require, among other things, that all medical students entering school be required to sign an agreement to practice for two years in an area designated by the Secretary of Health, Education and Welfare, regardless of whether or not the student received Federal financial assistance.

Mr. Edgar said medicine also was opposing sections of the bill that would establish Federal control of residency programs and Federal licensure and relicensure requirements.

State Legislation

Mr. Rader summarized the 110th Ohio General Assembly and pointed out possible areas of action for the 111th, as follows:

1. Medical Practice Act.
2. Physicians' Assistants.
3. Definition of Death.
4. Confidentiality of Medical and Peer Review Records.
5. "Disabled Physicians" Act.
6. Definition of "Provider."
7. Amendments to Arbitration Act.

The Councilors were encouraged to promote interest in legislative matters during visits to county medical societies and to hold fall district pre-election conferences where feasible.

Constitution and Bylaws

An amendment to the Scioto County Medical Society Code of Regulations **was approved** as submitted.

Guadalajara American-born Graduates

A memo was presented to the Council from the Ohio State Medical Board dated May 2, 1974, outlining the following policy on Guadalajara American-born graduates, adopted by the Board April 11, 1974:

"1) Dr. Press moved that the Board accept the Acta; and understanding that the Acta is given, the Board will then accept the Acta as equivalent of the Titulo and equivalent of a degree in Mexico. Dr. Crawford seconded the motion. All members voted aye. The motion was carried.

"2) Dr. Crawford moved that having accepted the Acta or Titulo as the equivalent of an M.D. degree, these men who are citizens of the U.S. may be admitted to the examination without additional training. Dr. Press seconded

the motion. All members were in favor and voted aye. The motion carried."

Study of Childhood Cancer

The Council received a memorandum from Mr. Clinger, which included a final draft of a proposal of the Ohio Cancer Coordinating Committee, Inc., for a study of the incidence and prevalence of childhood cancer in Ohio.

National Health Service Corps

The Executive Director pointed out the 1975 changes in the criteria to be used by the Department of Health, Education and Welfare for the designations of "critical" areas, eligible for the National Health Service Corps program are contained in DHEW's CHP Program Letter 74-10 of April 18, 1974.

"Certification of need and support of the project by local and state professional societies will still be required as a prerequisite to the review of the application," according to the Regional Program Director of NHSC.

Funding Student Attendance

A communication from the Academy of Medicine of Cincinnati, with regard to funding the attendance of medical students at medical meetings, was referred to the Committee on Public Relations.

Resolution from Osteopathic Association

A resolution of the Ohio Osteopathic Association regarding medication advertising received support of the Council.

Validation Surveys

A complaint and a resolution from the Shelby County Academy of Medicine concerning hospital "validation surveys" by the Social Security Administration duplicating the surveys of the Joint Commission on Accreditation was studied by the Council.

Dr. Henry announced that he had discussed the matter with Dr. John Budd, who is a member of the Joint Commission and of the AMA Board of Trustees. Dr. Budd will investigate the matter and report to the OSMA Council.

Anaesthesia Question

A letter requesting an interpretation of Sec. 4731.35 of the Ohio Revised Code, as to what constitutes a "prescribed course in anaesthesia" and "a hospital in good standing" was referred to the Committee on Maternal Health for study and advice to the Council.

OSMA Group Term Life

The following improvements in the OSMA Group Term Life Insurance were approved:

1. Increased the coverage to $75,000.
2. Another unit of life insurance added, regardless of health.
3. Decrease of premiums for members under age 40.

Evaluation Requested

A request for evaluation of care rendered was referred to Medical Advances Institute under established policy.

Harrison County Matter

Dr. Janis Trupovnieks, President of the Harrison County Medical Society, addressed the Council on a problem confronting that society.

The Council advised Dr. Trupovnieks and the Society to request specific information from the physicians and the hospital involved and then to direct a formal request to the OSMA for assistance in the matter.

Recertification Information Requests from Insurance Companies

A request from the Cleveland Academy of Medicine for review of practices by certain insurance companies in requesting recertification data was referred to the Committee on Insurance for study and advice to the Council.

Review Programs Criteria Development

Mr. Beaumont addressed the Council with regard to AMA work in the field of criteria development.

Ohio State Medical Journal

Dr. Jack Tetirick addressed the Council concerning the *Ohio State Medical Journal* and its future.

The Council recommended that the Committee on Membership and Planning meet with Dr. Tetirick to discuss his suggestions.

ATTEST: Hart F. Page
Executive Director

Definition of the Physician's Assistant in Ohio Is Approved by the OSMA Council

CONSIDERABLE STUDY is being given by the OSMA Committee on Health Manpower to the status of the physician's assistant in Ohio. Under the chairmanship of William E. Sovik, M.D., of Youngstown the Committee recently saw its first major recommendation — a definition of the physician's assistant — approved by OSMA Council. The definition is as follows:

"The physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant, and shall have successfully completed a proficiency examination developed and presented by the National Board of Medical Examiners."

The OSMA definition is similar to that adopted in 1970 by the American Medical Association although the latter does not mandate the examination for primary care P.A.'s by the National Board of Medical Examiners.

The NBME examination, which was developed in collaboration with the AMA, was given for the first time in December, 1973. Those eligible for the examination included graduates of programs approved by the AMA Council on Medical Education, graduates of programs receiving preliminary approval from the Council, graduates of programs funded by the Bureau of Health Manpower Education and graduates of programs of at least four month's duration within a nationally accredited school of medicine or nursing that trains pediatric or family nurse practitioners.

The 1974 NBME examination will have two major changes:

1. Eligibility for the examination will be expanded to include individuals who have been trained as physicians' assistants through work experience rather than through formal educational programs, and who have acquired four years of clinical experience in this capacity since 1970. (The details of an applicant's employment history will be verified by contacting the physician for whom she or he has worked.)

2. In addition to the one-day written examination, the 1974 Certifying Examination will include an assessment of physical examination skills. This assessment will take place at a different time from the written examination, and the details of the logistics are still being developed.

It should be noted that the legal status of the physician's assistant has not been defined in Ohio. It is anticipated that the Committee on Health Manpower will utilize the newly adopted definition to develop a legislative program for submission to the Ohio General Assembly early in 1975.

The proposed legislative program most likely will take the route of registration or certification for primary care P.A.s in Ohio. Licensure is currently opposed by OSMA and several other organizations including the AMA, American Hospital Association and Ohio Hospital Association.

OSMA Council approved the following recommendations of the Committee on Health Manpower:

"That OSMA Council, in order to promote the circulation of timely, effective information on physicians' assistants to the OSMA membership, authorize publication of a paragraph in the *OSMAgram* urging members to contact the OSMA for a copy of the AMA booklet *Employment and Use of Physician's Assistants—A Guide for the Physician.*"

In addition, copies of the following publications may be obtained by contacting the Committee on Health Manpower, OSMA, 600 S. High St., Columbus, Ohio 43215:

"Accredited Educational Programs For The Assistant To The Primary Care Physician" (AMA-March, 1974).

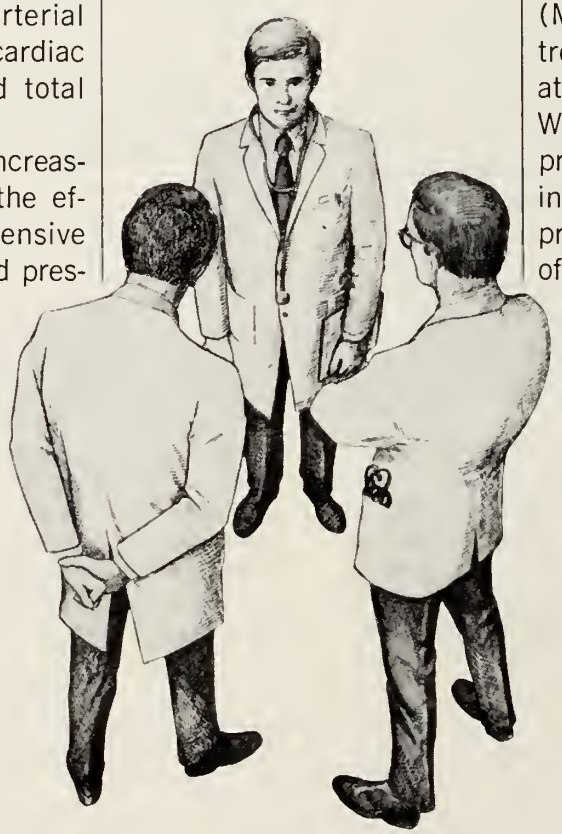
"Essentials of an Approved Educational Program For the Assistant to the Primary Care Physician" (AMA-December, 1971).

"Licensure of Health Occupations" (AMA Council on Health Manpower-1970).

The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

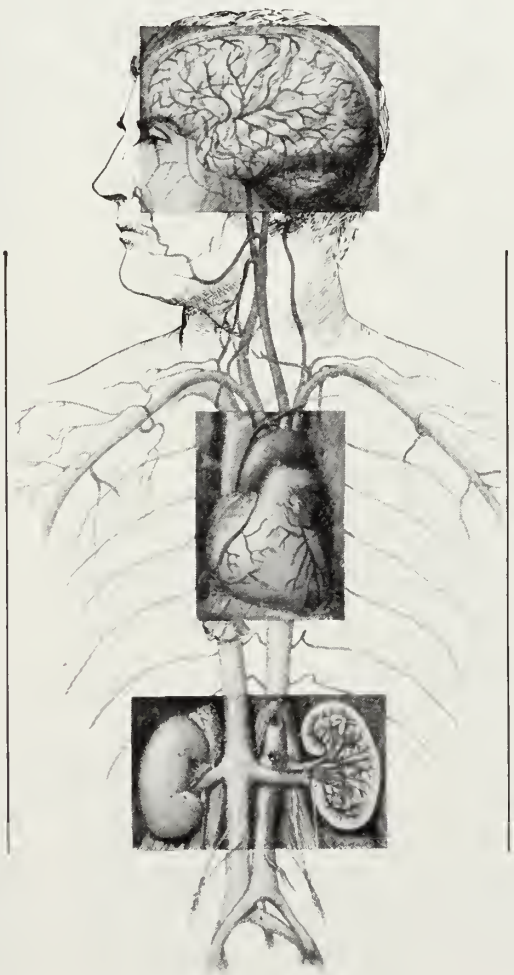
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?



With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in

the more physicians rely on this unique antihypertensive



vering blood pressure. But ere are other considerations well. Cardiac output is usuy maintained with no cardiac celeration; in some patients e heart rate is actually wed. Peripheral resistance apparently reduced. DOMET does not usually mpromise existing renal nction; it generally does not duce renal blood flow, glorular filtration rate, or filtion fraction. And ALDOMET ually does not cause symptoatic postural or exercise potension.

Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

NEW now available in 500 mg TABLETS as well as the standard 250-mg tablets

r a brief summary of prescribing information, ease see following page.

In most cases of sustained moderate hypertension

ALDOMET® (METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

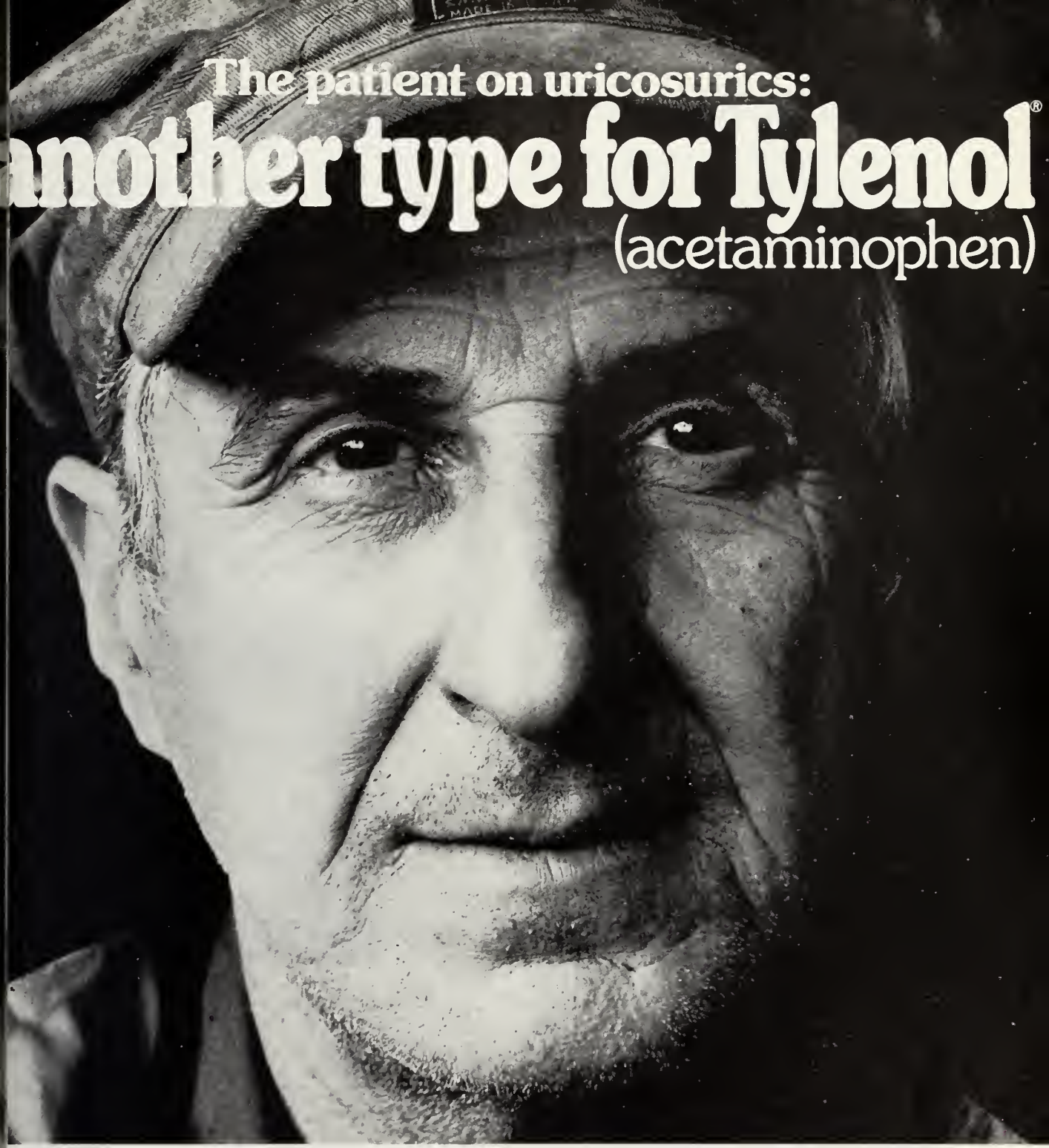
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The patient on uricosurics: another type for Tylenol® (acetaminophen)

When the patient on uricosuric therapy requires an analgesic, a new problem arises. Aspirin in the usual analgesic doses inhibits the action of uricosurics.[1,2]

TYLENOL (acetaminophen), on the other hand, causes no appreciable uricosuric antagonism[2] and for this reason is preferred over aspirin in the gout patient.

This is only one of several types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Martin, E.W., et al., ed.: Hazards of Medication, Philadelphia, J.B. Lippincott Co., 1971, p. 511. **2.** Seegmiller, J.E.: Med. Clin. North Amer. 45:1259-1272 (Sept.) 1961.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg.
For Children:
Elixir, 120 mg./5cc. (alcohol 7%).
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Chewable Tablets, 120 mg.

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Tylenol® (acetaminophen)

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Introducing OSMA's Expanded Field Service and Its Newly Appointed Director

THE Ohio State Medical Association, through me, your President, proudly presents its newly created Field Service Department and its Director, Robert E. Holcomb, who joined the Headquarters Executive Staff in July.

Groundwork for establishment of the Field Service Department was laid in a paragraph of Resolution No. 5-74, adopted by the OSMA House of Delegates at the 1974 Annual Meeting in Cleveland. The Resolution pertains to the increase in membership dues and the excerpt relating to the Field Service reads as follows:

". . . The Association must establish a full-time field service department to bring immediate assistance to the non-metropolitan county medical societies and to strengthen autonomy of their operations . . ."

The Association has had a limited field service for many years, but never a department devoted to that purpose, nor a full-time staff member who could do field work exclusively. In the past, the Executive Director and other members of the executive staff were available for telephone consultations and for limited trips into the field. Now that Mr. Holcomb has been appointed, he will devote his entire time to that purpose, and the field service will be expanded considerably.

The Field Service director will devote much of his time to consultations with County Medical Society officers, particularly in the non-metropolitan areas where full-time staffs are limited or nonexistent. He will familiarize County Medical Society officers and other physicians in key positions with current information and services available from the Headquarters Office in Columbus and from the American Medical Association's offices in Chicago and Washington.

As part of the process of exchanging ideas, he will convey to the Columbus office the needs of County Medical Societies and bring to the attention of Association officers any input they may have toward policy and thinking of the Association. In short, he will be the liaison man between County Medical Societies and the State Association.

One of the local activities he will help with is the development of programs. Both the OSMA and the AMA maintain Speakers' Bureaus, listings of physicians and others who are willing to speak before local groups on specific subjects within their fields of expertise. He may be of help in arranging programs on scientific subjects, perhaps through the cooperation of Ohio's four medical schools. He also can help in arranging speakers for programs on social, economic or legislative issues that have a bearing on the practice of medicine.



James L. Henry, M.D.
President, Ohio State Medical Association

Obviously, the Field Service director will not stand alone. On the Executive Staff are persons who devote their particular attention respectively to public relations, legislation, liaison with governmental agencies, rural health and school health, insurance, and so forth. When it is considered advisable, the Field Service Director will arrange conferences between County Medical Society officers and members of the Executive Staff.

By nature of his office, the Field Service director will be on the road much of the time, but when he is away from the Columbus office what amounts to a "hot line" will be available. More specifically, when a County Medical Society officer needs his advice or help in a given situation, the officer may phone the Headquarters Office and have a message relayed for a speedy contact.

It is most important from the standpoint of the public health and maintenance of the physician-patient relationship that the Medical Profession show a united front — an effort that would demonstrate unity of purpose with due regard for individual rights and opinions. This means a give-and-take relationship between the County Medical Society, the Ohio State Medical Association, and the American Medical Association. Our new Field Service director will enhance this common purpose.



Robert E. Holcomb
Field Service Director

Let me point out that the Field Service director is at your service to help you the County Medical Society officers and members where you feel the need exists. The Field Service, as the Resolution states, is to "strengthen the autonomy" of the local Societies and to help develop a closer relationship with the State Association. We present the Director as a man who is ready to help where the need arises.

A native of Dayton and recent resident of that city, Mr. Holcomb attended public schools through high school there. He earned a Bachelor of Arts degree at Muskingum College, he studied law for one year at Salmon P. Chase School of Law in Cincinnati.

He was drafted at the age of 26 and assigned to active duty with the U.S. Navy. A four-year tour of service included one year in the Vietnam Conflict, following which he received a Letter of Commendation for individual achievement.

Most of his experience has been public relations oriented, including an association with the firm of Allbery and Roberts, Attorneys-at-Law, and service with State Farm Insurance Company and Connecticut Mutual Life Insurance Company.

Mr. Holcomb is married to the former Marilyn D. Flint, of Westerville. They have two daughters, Colleen, age 5, and Katie, age 2.

OSU Gets Major Regional Cancer Research Center

The National Cancer Institute has awarded a grant of $2.3 million to Ohio State University in support of a major regional Cancer Research Center for Ohio.

The grant will support management and administration of all cancer projects at Ohio State, some centralized laboratory facilities and seven regional clinical programs. For the first year, federal support will be $805,533. Commitments for the following two years are $731,571 and $763,539, the NCI announced.

The university, which has 88 investigators from seven colleges engaged in some 109 separate cancer research projects, has been planning the major center since 1972. At that time it received a 2-year planning grant of $240,000.

Last year the university established a Cancer Center with Dr. David S. Yohn as director and Dr. Albert F. LoBuglio as deputy director. The center has its offices in Lincoln Tower, 1800 Cannon Dr.

AMA Inaugurates Medical Scholarships

A 20-year $480,000 scholarship program has been inaugurated by the American Medical Association Education and Research Foundation (AMA-ERF) with the naming of the first 12 senior medical students as Rock Sleyster Scholars. Each will receive a $2,000 grant for the 1974-75 school year.

Twelve one-year scholarships, totaling $24,000, will be awarded during each of the 20 years to medical students on the basis of scholarship, financial need, and demonstrated interest in psychiatry, according to Kenneth C. Sawyer, M.D., AMA-ERF president.

Dr. Sawyer said the program was made possible through a $380,000 bequest of the late Mrs. Clara S. Sleyster, of Shorewood, Wis., a suburb of Milwaukee, which established a memorial fund to honor her husband, Rock Sleyster, M.D., president of the American Medical Association in 1939-40.

The nominees are evaluated by a committee of medical educators working with the AMA Department of Undergraduate Medical Education.

Obituaries

Nikaan B. Andersen, M.D., Cleveland; medical degree from the University of Copenhagen, 1955; aged 46; died June 29; member of OSMA.

James Orin Barr, M.D., Chagrin Falls and South Russell: Western Reserve University School of Medicine, 1937: aged 62: died June 29; member of OSMA and AMA.

Ray Louis Davis, M.D., Hamler; Ohio State University College of Medicine, 1915; aged 88; died July 17; member of OSMA and AMA.

Martin Walter Diethelm, M.D., Toledo; St. Louis University School of Medicine, 1918; aged 80; died July 12; member of OSMA and AMA.

Enrico DiIorio, M.D., Naples, Italy; formerly of Youngstown: medical degree from the University of Naples, 1914: aged 84: died July 1; member of OSMA and AMA.

Charles G. Goll, M.D., Stryker; Northwestern University Medical School, 1909; aged 90; died July 18: member of OSMA and AMA.

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For further information, write or call the Medical Secretary, **The University Center, Box 621, Ann Arbor, Michigan 48107,** Telephone: 313-663-5522. Brochure is available upon request.

ARNOLD H. KAMBLY, M.D.
Psychiatrist-Director

Raymond Lemoyne Johnston, M.D., Dayton; Johns Hopkins University School of Medicine, 1923; aged 78; died July 15; member of OSMA and AMA.

Louis Dewey Lebold, M.D., Warsaw (formerly of Akron); University of Cincinnati College of Medicine, 1925; aged 75; died July 21; member of OSMA and AMA.

Charles Nathan Loeser, M.D., Storrs, Conn.; formerly of Cleveland; Western Reserve University School of Medicine, 1947; aged 52; died July 17.

Robert Alfred Louviaux, M.D., Toledo; Ohio State University College of Medicine, 1959; aged 40; died June 26; member of OSMA.

David Slocum Mack, M.D., Medina; Ohio State University College of Medicine, 1947; aged 53; died July 7; member of OSMA and AMA.

Samuel Miller, M.D., Hollywood, Fla.; formerly of Akron; Baltimore Medical College, 1912; aged 84; died May 25; member of OSMA and AMA.

Willis Seamans Peck, M.D., Toledo; State University of New York Upstate Medical Center, 1924; aged 74: died July 8; member of OSMA and AMA.

Edward William Sanders, M.D., Bellevue; University of Cincinnati College of Medicine, 1941; aged 65; died July 1; member of OSMA and AMA.

John Lawrence Scarnecchia, M.D., Youngstown; Georgetown University School of Medicine, 1929; aged 68; died July 16; member of OSMA and AMA.

Kenneth Durward Smith, M.D., Columbus; Ohio State University College of Medicine, 1929; aged 69; died July 11; member of OSMA and AMA.

Joseph Tomarkin, M.D., Cleveland; Western Reserve University School of Medicine, 1928; aged 72; died July 21; member of OSMA and AMA.

Norman William Theissen, M.D., Lakewood; Harvard Medical School, 1934; aged 69; died July 17; member of OSMA and AMA.

Paje F. Weil, M.D., Cincinnati; medical degree from the University of Vienna, 1920; widow of the late Joseph Weil, M.D.; aged 87; died June 23.

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Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

THIS IS COUNTY "Catch Up Time" and I really have a lot of catching up to do! Because of state and national conventions which had to have precedence in recent months, I have had to hold back on some very fine county reporting. I'm sorry about that, of course. But it certainly isn't too late to talk about some really terrific grass roots "doin's."

It was a free community service for the young residents of **Lucas County** — the two-day testing for infants, toddlers and pre-schoolers of their hearing, speech and vision at the Zucker Center in Toledo. Held some months ago, this was one of the auxiliary's major projects for the 1973-74 year and it was a "first" and it was outstanding. Approximately fifty members volunteered their services under the chairmanship of Carolina Smith and Julie Mahoney. One hundred and seventy-five children were screened, in cooperation with the Family Learning Center and other community service organizations, physicians and other specialists who volunteered their services. As a result of the screening, approximately one hundred of the children were discovered to have some hearing, speech and vision problems of varying degrees. The Lucas auxiliary has been further evaluating the project with the hope that if it is to be continued, it may also be expanded. Not so incidentally, "communications" was at its best in this effort.

The **Lucas** group's Mobile Meals community program continues to be another major activity of great stature. Presently there are 167 subscribers, 21 routes and 7 hospital bases! In order to maintain this impressive service, some **seven hundred working volunteers** are involved. During the last six years, Mobile Meals has continued to serve a total of 940 new subscribers. There was a volunteer recognition tea at the Academy of Medicine in late Spring at which 66 five-year pins were awarded, which is quite remarkable considering that fifty such five-year pins were awarded last year!

The **Allen County** auxiliary donated $3,822.21 to AMA-ERF via its Mini-Bazaar and Christmas sharing card . . . . purchased cassettes concerning venereal disease education to be shown to patients in the waiting room at the Board of Health . . . . . 5,500 students viewed the VD films that were purchased earlier and are used continually by the group . . . . . undertook a community survey to determine the prevalence of child abuse and neglect and then wrote and sponsored spot announcements concerning the battered child for the local radio station . . . . . also there was a one-day concentration at the local shopping center where films were shown and literature distributed dealing with child abuse, and at which

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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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case workers from the Children's Service were present to answer questions.

Cuyahoga County's annual Lilac Luncheon a few months ago was another beautiful traditional occasion. I had the privilege of being present at the Somerset Inn in Cleveland where the festivities were held. Each year the group's Philanthropy Fund benefits well from this colorful and entertaining day that this year featured a Silent Auction and a stunning Fashion Show. The Silent Auction netted over $2,000.00. I recommend it heartily to other county auxiliaries as a marvelous way to make money and at the same time provide an afternoon or evening of unusual "shopping," fun and interest. Cuyahoga's annual Springtime luncheon in late May was held at the Hillbrook Club and featured as guest speaker Dr. Raymond N. Ferreri who discussed "Recent Advances in Biological Psychiatry." This luncheon meeting was also the scene of installation of the 1974-75 officers. Mrs. John Liambeis is the new president; Mrs. Kenneth V. Harshman the outgoing president.

The Columbus Gallery of Fine Arts was the scene of another installation — this time of the **Franklin County** auxiliary, at which Mrs. Donal O'Leary, the 1973-74 president, turned over her gavel to Mrs. Donald Lewis, the 1974-75 "captain of the team" . . . . . There was a dessert tea and there was a tour of the Gallery's New Addition.

Licking County auxiliary's second annual Champagne Buffet and Benefit Auction was held this past Spring and was another tremendous success. Some of the exciting "items" offered for auction included dinner parties, tennis parties, the use of condominiums in Barbados and Aspen, aged fire wood and a trail bike, all donated by auxiliary members and their husbands. Through the generosity of the three hundred guests, 14 young women from Licking county will be started on their way to paramedical careers. Chairman of the auction was Mrs. Michael Thorne. "We would like to share our success with other doctors and doctors' wives," writes Mrs. Michael Ratterman, publicity chairman. "If there are any questions, please let other auxiliaries know they may contact me (49 Joy Lane, Granville 43023) or Mrs. Frederick Karaffa (Goose Lane, Granville, 43023.)"

Summit County's Mobile Meals is another such program doing a fantastic job. Approximately 2,400 meals are delivered each month by 350 volunteers. During the 1973-74 auxiliary year, the group was involved in three fund-raising events for Mobile Meals: a Monte Carlo night which netted $2,312; a Holiday Auction and Tea which netted $1,181; and the Watch Fund which netted $1,300. The Betty Dobkin Nursing Scholarship Fund gave nine student nurses each three hundred dollars toward their tuition. Fifty subscriptions to *Today's Health* is given annually to the area's junior and senior high school libraries. And Summit's contribution to AMA-ERF was a whopping $4,118.48.

All of the foregoing is just a sampling of county auxiliary activity. Don't you agree that our doctors' wives deserve some thundering applause???



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In This Issue:

The Brown Pharmaceutical Co., Inc. 548, 552, 589

Burroughs Wellcome Co. 553

Capital Financial Services 550

Dorsey Laboratories, Div. of Sandoz-Wander, Inc. 541, 551, 585

Flint Laboratories, Div. of Travenol Lab., Inc. 565

Immke Circle Leasing 537

Lilly, Eli and Company 556

McNeil Laboratories, Inc. 581

Mead Johnson Laboratories 587

The Medical Protective Co. 589

Merck, Sharp & Dohme, Div. of Merck & Co, Inc. 578-579-580

Ohio Medical Indemnity 549

Pharmaceutical Manufacturers Association 568-569

Robins, A.H., Company 543-544

Roche Laboratories, Div. of Hoffman-LaRoche, Inc. .....Inside Front Cover, 535, 554-555, Inside Back Cover and Back Cover

Wm. H. Rorer, Inc. 547

G.D. Searle & Co. 566-567

Turner & Shepard, Inc. 586

University Center 584

The Upjohn Company 538-539

Wendt-Bristol Co. 588

Windsor Hospital 545

Wolman Insurance Agency, Inc. 542

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THE CANDIDATE REVIEW COMMITTEE of the Ohio Mental Health and Mental Retardation Advisory Council is now accepting letters of application for the position of Director of the Ohio Department of Mental Health and Mental Retardation. Letters of application or inquiry should be sent to: Ms. June Garvin, Staff Assistant, Advisory Council, Candidate Review Committee, Ohio Department of Mental Health and Mental Retardation, 2929 Kenny Road, Columbus, O. 43221.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.



Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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(chlordiazepoxide HCl)

Please see reverse side for summary of product information.

The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

VOLUME 70 OCTOBER 1974 NUMBER 10

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON

OCT 30 1974

Original Articles

Cervical Carcinoma In Situ at Akron General Medical Center. The Value of Colposcopy. William T. Yates, M.D., and William A. Cook, M.D., Akron 625

Slipped Femoral Capital Epiphysis. David K. Halley, M.D., Columbus 628

Agenesis of Gallbladder. Case Report and Discussion. Henry W. Brown, M.D.; Elias M. Nicolas, M.D.; and Madhira D. Ram, M.D., Cleveland 630

Thermographic Demonstration of Tenosynovitis. A Case Report. Roger B. Traycoff, M.D., Philadelphia; Kenneth M. Malin, M.S., Columbus; Keith L. Ewing, Ph.D., Kent; and Bernard J. Rubal, M.S., Houston 632

Your AMA at Work

American Medical Association Clinical Convention in Portland Promises Excellent Features 634

Physicians' Art Show Awards

List of Award Winners at the 1974 OSMA Annual Meeting Art Show 636

Public Health

Ohio Department of Health Reports Malaria Is Still Around; Influenza Season Is Here 596

Medical College Activities

University of Cincinnati College of Medicine to Dedicate Its New Home 594

With the County Societies

Cincinnati Needs Furnishings to Recreate Civil War Period Office 599

Scioto County Medical Society Seminar Scheduled as Annual Event 616

Keeping Up

Continuing Education Courses for Physicians Scheduled Throughout Ohio 602

Family Physicians

Ohio Academy of Family Physicians Names Officers for the Year 611

Woman's Auxiliary

Woman's Auxiliary Highlights 639

With The Journal

News Editor Named to Staff of The Journal 637

The Journal's Advertisers in This Issue 640

Classified Advertisements 641

Other Features

Medic Alert Needs Public Interest 638

Obituaries 614

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Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard anti convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and mus cle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

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According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



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in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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VOL. 70 OCTOBER, 1974 No. 10

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The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientifc and educational purposes.

Subscription, $5.00 per year to nonmembers; single copy, 50 cents (outside Continental U.S., $6.50 and 65 cents).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertiser must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

Cincinnati Medical College To Dedicate Its New Home

Dedication ceremonies for the University of Cincinnati's new $50.7 million College of Medicine Building will take place during the afternoon of October 11. The Honorable Casper W. Weinberger, Secretary of Health, Education, and Welfare, will deliver the dedication address in the building's Kresge Auditorium.



The 10-story building contains classrooms, laboratories, and the Medical Center's Health Sciences Library in its 21 acres of floor space. Connected at five levels to Cincinnati General Hospital, the building links teaching and research facilities with patient care areas.

Construction was started in December, 1970, and completed last spring, bringing all of the College of Medicine's operations under one roof for the first time in its history.

In conjunction with the dedication, the Mont Reid Surgical Society scientific program and the Department of Medicine alumni reunion will be held October 10. Several other groups will meet October 12: Division of Urology reunion and special teaching conferences; Department of Psychiatry scientific program; Department of Pediatrics reunion and open house; and Health Sciences Library Symposium.

The 1974 Scientific Assembly of the American Academy of Family Physicians will be held October 14-17 in Los Angeles, California. The educational program will begin immediately after the close of the annual meeting of the Academy's policy-making Congress of Delegates, which will be held October 12-14 at the Los Angeles Hilton.

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Community Health News

Ohio Department of Health

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Malaria

A number of cases of malaria, including fatal cases, has occurred in travelers returning from countries where malaria is endemic. Most of these cases could have been avoided if proper chemoprophylaxis had been taken by the travelers.

Physicians should prescribe chemoprophylaxis for any of their patients traveling to endemic areas. The currently recommended medication is Chloroquine phosphate — a 500 mg. tablet to be taken once a week on the same day of each week. Travelers should begin taking the drug two weeks before departure, during their stay, and for six weeks after their return to the United States.

During their stay in malarious areas, travelers should be advised to avoid mosquito bites as much as possible by using repellents and sleeping in screened rooms or in mosquito nets.

Information on areas where malaria transmission is occurring is available from the Communicable Disease Division, Ohio Department of Health.

Influenza Vaccination

The influenza season is again approaching and it is time to think about vaccination. The U.S. Public Health Service recommendations on influenza vaccine usage are based on the facts that during influenza epidemics mortality is essentially restricted to the chronically ill and the elderly, as well as reasonably low attack rates in community outbreaks and the low frequency of serious complications from the disease in healthy people. For these reasons selective vaccination of "high-risk" individuals is recommended. Of note is the finding from immunization surveys that only 10-15 percent of this group are vaccinated each year. Influenza control through widespread community vaccination is not recommended at this time.

Bivalent vaccine this year will contain a new type A influenza virus representative of current "England" strains. It is an inactivated vaccine prepared from viruses grown in embryonated eggs and should not be administered to persons hyper-

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Cold or



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INDICATIONS Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS *Use in children:* In infants and children, particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
ADVERSE REACTIONS Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation and epigastric distress.
HOW SUPPLIED Light blue Extentabs in bottles of 100 and 500.

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23220

when pain goes on... and on... and on–



For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. A·H·ROBINS

sensitive to egg proteins. Vaccination is recommended for all persons who have chronic conditions as (1) heart disease of any etiology, particularly with mitral stenosis or cardiac insufficiency; (2) chronic bronchopulmonary diseases, such as asthma, chronic bronchitis, bronchiectasis, and emphysema; (3) chronic renal disease; and (4) diabetes mellitus and other chronic metabolic disorders. Annual vaccination is recommended for persons over age 65 years. Vaccination may be considered for persons who provide essential community services if local priorities justify.

In the past the primary series of bivalent vaccine has been two doses. However, with the advent of more potent vaccines with greater antigenic loads it is now reasonable to give a single dose of vaccine for either primary or annual booster vaccination, as the second dose provides little additional benefit.

Influenza vaccine should be administered by mid-November.

Adapted from Recommendations of the Public Health Service Advisory Committee on Immunization Practices — Influenza Vaccine, MMWR 23: 215, June 15, 1974.

Cincinnati Needs Furnishings To Recreate Civil War Office

A Civil War Physician's Office and Waiting Room is being refurbished by the Academy of Medicine of Cincinnati in cooperation with a historical project sponsored by the Miami Purchase Association. In order to provide a suitable display, the Academy urgently needs the following items:

A small rolltop desk with a brass base or other light and physician's chair; glass-faced medicine cabinet; glass-faced instrument cabinet; old medical jars of that era; medical chest (small) with drawers for tablets, pills, etc.; non-metal tub for Sitz Baths; old chairs, curtains, scales, rag carpeting or rugs; old saddle bag; old lights for office and waiting room; old patients' chairs and settee; two old "Shaker" stoves about three feet tall and wood-burning of cast iron; old stethescope; old brass microscope; etc.

Any suggestions for the display will be greatly appreciated by the Academy. Address all responses to: Clyde S. Roof, M.D., Chairman, Committee on History, Academy of Medicine of Cincinnati, 320 Broadway, Cincinnati, Ohio 45202.

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IMMEDIATE RELEASE		GRADUAL RELEASE
LIPO-NICIN/100 mg. Each blue tablet contains: Nicotinic Acid .....100 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 5 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/250 mg.** Each yellow tablet contains: Nicotinic Acid .....250 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/300 mg.** Each timed-release capsule contains: Nicotinic Acid .....300 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

WRITE FOR LITERATURE AND SAMPLES

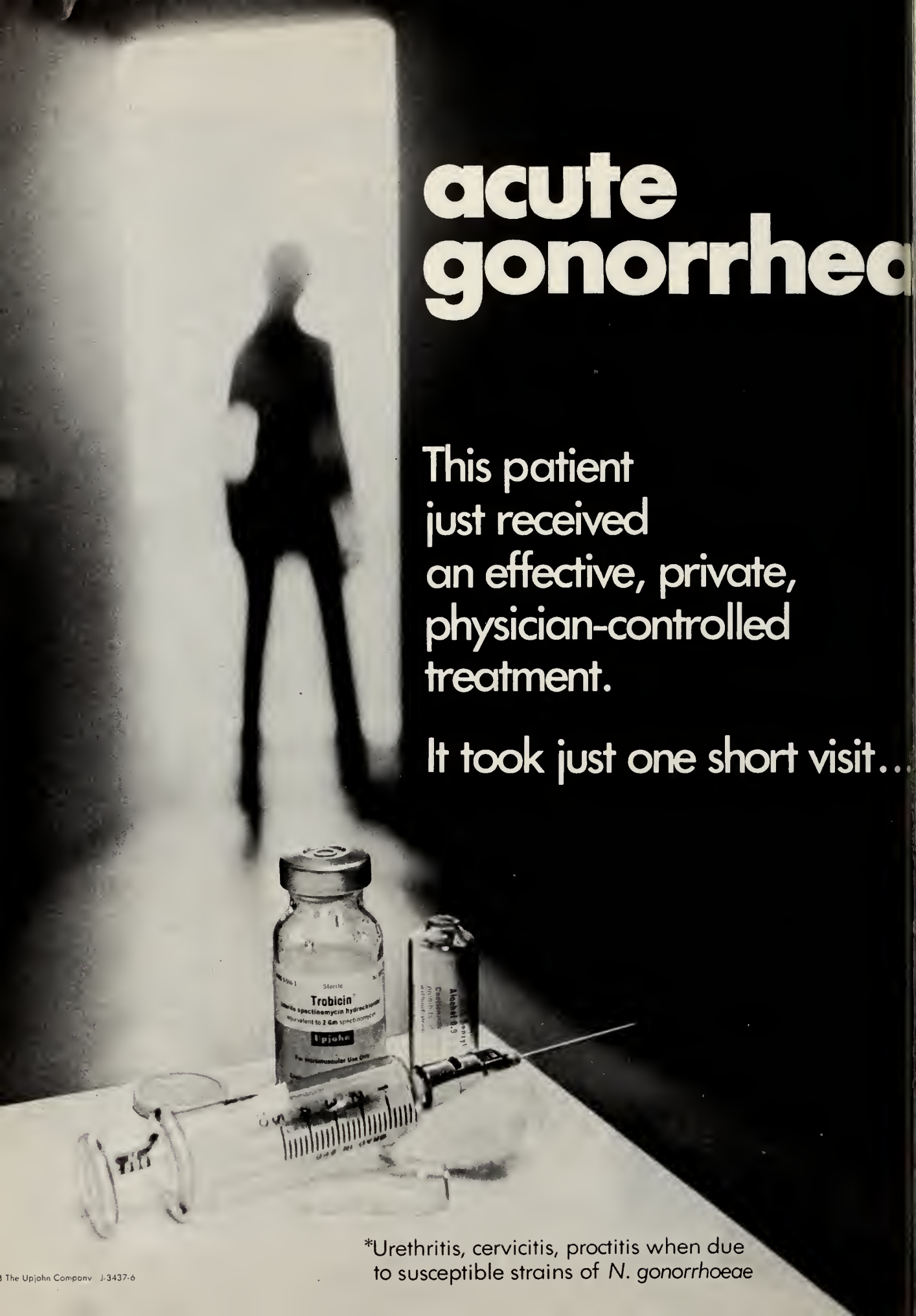
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REFER TO PDR

acute gonorrhea

This patient
just received
an effective, private,
physician-controlled
treatment.

It took just one short visit...



*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

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sterile spectinomycin hydrochloride

rile Trobicin
ile Trobicin (spectinomycin hydrochloride) or Intramuscular Injection:
n vials containing 5 ml when reconstituted diluent
n viols containing 10 ml when reconstituted diluent.
minocyclitol antibiotic active *in vitro* against strains of *Neisseria gonorrhoeae* (MIC 7.5 0 mcg/ml). Definitive *in vitro* studies have vn no cross resistance of *N. gonorrhoeae* veen spectinomycin and penicillin.

ications: Acute gonorrheal urethritis proctitis in the male and acute gonorrheal icitis and proctitis in the female when due usceptible strains of *N. gonorrhoeae*.

traindications: Contraindicated in pa- s previously found hypersensitive to spec- nycin.

rnings: Not indicated for the treatment of ilis. Antibiotics used to treat gonorrhea mask or delay the symptoms of incubating ilis. Patients should be carefully examined monthly serological follow-up for at least nths should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautians should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bocteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with o concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the pockoge insert.

Upjohn MED 8-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

or patients with gonorrheal proctitis and for patients in geographic areas where antibiotic sistance is known to be prevalent, initial treatment with 4 grams is preferred.

Continuing Education Opportunities for Physicians in Ohio

October

Ninth Annual Cancer Symposium — Sponsored by Akron City Hospital on Oct. 16-17. Fee is $10. Presented by a team from The Ohio State University School of Medicine. For further information, contact Institute of Medical Education, Akron City Hospital, Market and Arch Streets, Akron, 44309.

Myocardial Revascularization Surgery 1974—A Selection of Patients, Pitfalls and Postoperative Results. Oct. 16-17; fee is $80; contact: Cleveland Clinic Educational Foundation, 9500 Euclid Ave. Cleveland 44106.

A Day of Infectious Disease — Oct. 16; fee is $5; contact the Institute of Medical Education, Akron City Hospital, Market and Arch Sts., Akron 44309.

Association of Physicians of the State of Ohio, Quarterly Session, in the Columbus area, place to be announced, Oct. 17-18. Contact: Virginia S. Edwards, M.D., Secretary-Treasurer, 347 Lexington Ave., Mansfield 44907.

American Association for Laboratory Animal Science—25th Annual Meeting, Cincinnati Convention-Exposition Center, Cincinnati, Oct. 21-25; contact: Executive Secretary Joseph J. Garvey, AALAS, 2317 W. Jefferson St., Suite 208, Joliet, Illinois 60435.

Office Evaluation & Management of Elevated Blood Pressure — Stouffer's Cincinnati Inn, 5th St., Cincinnati; Oct. 24. Co-sponsored by CIBA Pharmacy; contact: University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, 234 Goodman St., Cincinnati 45229.

Reye's Syndrome—Sponsored by the Children's Hospital Research Foundation; at the Neil House, Columbus, Oct. 29-30; contact: J. Dennis Pollack, Ph.D., 215 Ross Hall, The Children's Hospital, 561 South 17th St., Columbus 43205.

November

Vascular Disease — Stouffer's University Inn, 3025 Olentangy River Rd., Columbus; Nov. 1-2; fee is $60; contact: Ohio State University College of Medicine, Center for Continuing Medical Education, 320 W. 10th St., Columbus, 43210.

Biomechanics — Cleveland Plaza, Euclid at E. 12th St., Cleveland; Nov. 4-8; $150 fee for MD's and $50 for residents; contact: American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, Illinois, 60611.

Hemolytic Transfusion Reactions — Cleveland Clinic; Nov. 6-7; fee is $75; contact: American Society of Clinical Pathologists, 2100 W. Harrison, Chicago, Illinois, 60614.

(Continued on Page 604)

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A Complete Source of Supply . . .
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Biennial Opthalmology — University of Cincinnati Medical Center, Cincinnati; Nov. 8-9; contact: University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, 234 Goodman St., Cincinnati, 45229.

Reconstructive Surgery of the Knee — Park Plaza, 2065 E. 96th St., Cleveland; Nov. 11-13; $150 fee for MD's and $50 for residents; contact: American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, Illinois, 60611.

Newborn Infants 1974 — University of Cincinnati Medical Center, Cincinnati; Nov. 13; fee is $20; contact: University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, 234 Goodman St., Cincinnati, 45229.

Case Western Reserve University, Pediatric Clinical Faculty, Fourth Annual Symposium, November 13-14. Topic: **Pediatrics — Prognosis and Prophylaxis.** Subjects will include the role of ambulatory pediatricians and the health team in primary care, and onrushing changes for physician and child in the delivery of pediatric care. Faculty: Evan Charney, M.D., Frederick Robbins, M.D., Jerome Liebman, M.D., Samuel Horwitz, M.D. Fee: none. For additional information, contact: S. S. Strassman, M.D., chairman, Pediatric Clinical Faculty, Rainbow Babies and Childrens Hospital, University Circle, Cleveland 44106.

Clinical Progress in Gastroenterology — Akron City Hospital, Akron; Nov. 20; fee is $5; contact: Institute of Medical Education, Akron City Hospital, Market and Arch Sts., Akron, 44309.

Gastroenterology: Clinical Problems — Nov. 20-21; fee is $80; contact: Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland, 44106.

Gout and Other Metabolic Arthritides — University of Cincinnati Medical Center, Cincinnati; Nov. 21-22; contact: University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, 234 Goodman St., Cincinnati, 45229.

Gastroenterology for the Primary Physician— Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; Nov. 30-Dec. 1; fee is $50; contact: The Ohio State University College of Medicine, Center for Continuing Medical Education, 320 W. 10th St., Columbus, 43210.

December

Fluid and Electrolyte With Special Emphasis on Urologic Problems — University of Cincinnati Medical Center, Cincinnati; Dec. 4; fee is $35; contact University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, 234 Goodman St., Cincinnati, 45229.

Urology X-Ray — Netherland Hilton Hotel, 5th St., Cincinnati; Dec. 5-7; contact: University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, 234 Goodman St., Cincinnati, 45229.

Cardiology — Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; Dec. 6; fee is $40; contact: The Ohio State University College of Medicine, Center for Continuing Medical Education, 320 W. 10th St., Columbus, 43210.

A Day of Cardiology — Akron City Hospital, Akron; Dec. 18; fee is $5; contact: Institute of Medical Education, Akron City Hospital, Market and Arch Sts., Akron, 44309.

March 1975

Core Curriculum: Pediatric Echocardiography — Sponsored by the American College of Cardiology, Cincinnati, March 17-20, 1975. For details, contact: American College of Cardiology, Department of Continuing Education Programs, 9650 Rockville Pike, Bethesda, Md. 20014.

May 1975

Microneurosurgery Symposium, Cincinnati Convention Center, May 29-31, 1975. Directors: Stewart B. Dunsker, M.D., and John M. Tew, M.D. Lectures, practical demonstrations and discussions will be provided by an international faculty. Special courses for nurses and surgical assistants also will be conducted. Sponsored by the Departments of Neurosurgery, The Christ and Good Samaritan Hospital, Frank H. Mayfield,, M.D., Director. For details, write: Ms. S. Stuckey, Coordinator, Microneurosurgery Symposium, 506 Oak St., Cincinnati 45219.

an effective combination of medication and psychology for rheumatoid arthritis



unique 10-grain buffered aspirin

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Each tablet contains aspirin, 600 mg. (10 grains); magnesium hydroxide, N.F., 150 mg.; aluminum hydroxide dried gel, 150 mg.

Unique design. In shape, size and color, CAMA looks like no other aspirin. It gives patients an "individualized" medication—one they may find more acceptable and possibly respond to more positively.

Fits prescribing patterns. CAMA's 10-grain aspirin strength is suited to the higher dosage regimens generally used for arthritis.

Adjustable dosage. Scored tablet lets you increase or decrease dosage in 5 or 10 grain increments.

Economical. CAMA costs no more per dose than many 5-grain buffered aspirin tablets. Give your arthritic patients the added benefits of CAMA. Ask your Dorsey representative for a generous supply or write Director of Professional Relations.

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Cleveland and Columbus January 10

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Enclosed is my check for $_____ ($100 per person) as a deposit. I understand the total deposit will be refunded if it becomes necessary to cancel my African Adventure membership at least 60 days before departure, when final payment is due. Make your check payable to: Manchester Bank, African Adventure, Trust Account.

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Healing nicely, but it still HURTS

HERE Burns



When parenteral analgesia is no longer required, Empirin Compound with Codeine usually provides the relief needed.

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Empirin Compound with Codeine is effective for visceral as well as soft tissue pain—provides an antitussive bonus in addition to its prompt, predictable analgesia.

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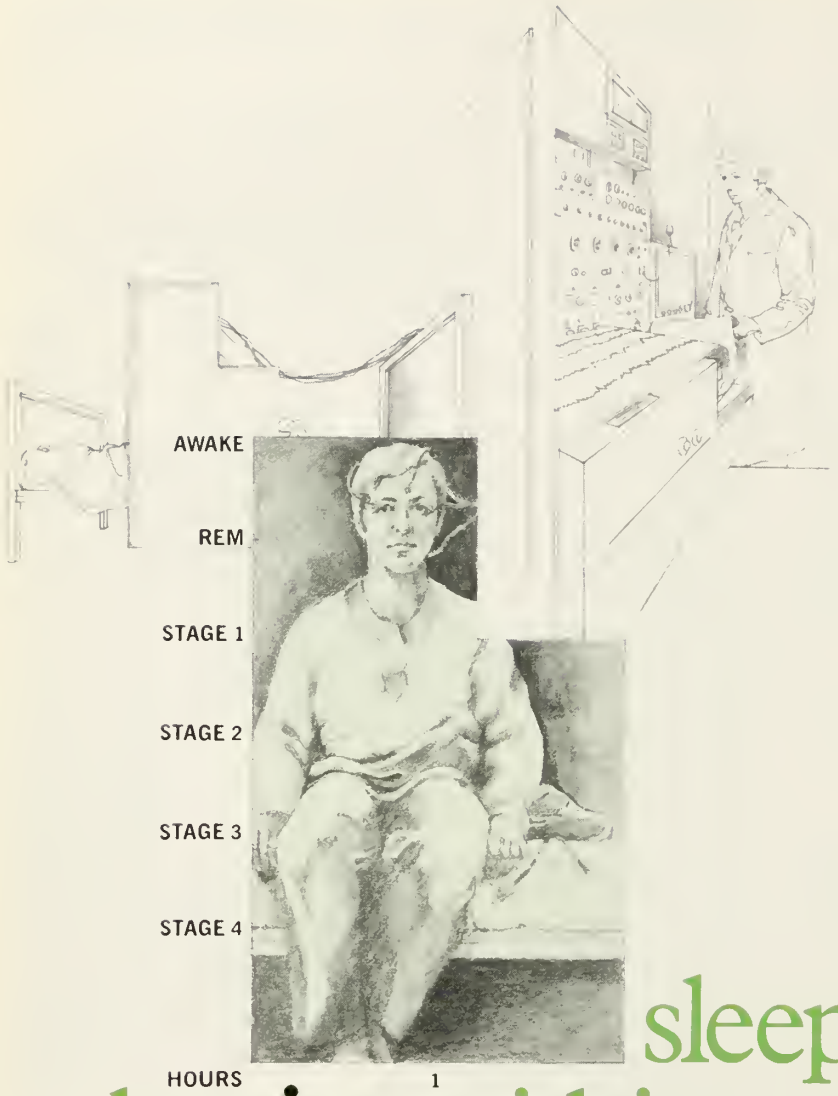
Empirin Compound with Codeine **No. 3,** codeine phosphate* 32.4 mg. (gr. ½); **No. 4,** codeine phosphate* 64.8 mg. (gr. 1). *Warning—may be habit-forming. Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.

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EMPIRIN® COMPOUND c̄ CODEINE

#3, codeine phosphate* (32.4 mg.) gr. ½
#4, codeine phosphate* (64.8 mg.) gr. 1

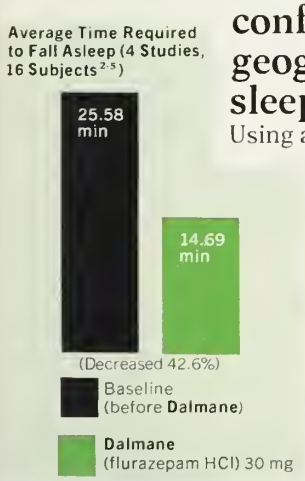


sleep begins within 17 minutes, on average ... an initial benefit of

Dalmane®
(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories [2-5]

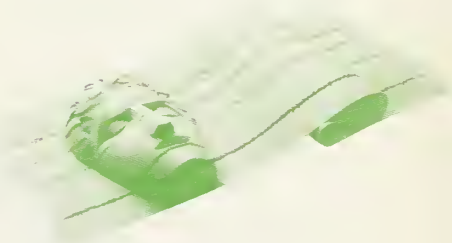
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A. *et al*: *Arch Gen Psychiatry* 23:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Nutley, New Jersey 07110

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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*E.D. Freis: The Modern Management of Hypertension. V.A. Information Bulletin, 11-35.

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Ohio Academy of Family Physicians Names Officers for the Year

Carl E. Spragg, M.D., New Concord, was installed as the 27th President of the Ohio Academy of Family Physicians in Cleveland early in August. He succeeds David A. Barr, M.D. of Lima.

The statewide 1700 member family physician organization held its annual scientific assembly at the Cleveland Plaza Hotel. Governor John J. Gilligan proclaimed the week of the meeting as Family Physician Week.

Other new officers installed are Doctors Alford C. Diller, Convoy, President-Elect; Kenneth A. Frederick, Cincinnati, Vice-President; Henry R. Silverman, Toledo, Treasurer; Robert L. Reinhart, Columbus, Speaker of House; Andreas S. Ahbel, Canton, Vice-Speaker of House; Fred V. Light, Cleveland, and Robert S. Young, Johnstown, national delegates; and David A. Barr, Lima, national alternate.

Newly elected directors are Doctors Oliver K. Roth, Cincinnati; William A. Stowe, Dayton; Daniel R. Sullivan, Toledo; Janis Lauva, Wellsville; Robert R. Johnson, Coshocton; Tennyson Williams, Columbus, and Rocco M. Antenucci, Mogadore.

During the Annual Banquet, John H. Rosemond Jr., M.D., Columbus was selected as the Family Physician of the Year for his dedication and service to his community and his diligent pursuit of the principles of family practice. Others honored were Robert S. Young, M.D., Johnstown, for his outstanding legislative services; Harold V. Ellingson, M.D., Columbus, for his leadership and guidance in the development of family practice programs; and K. K. Solacoff, M.D., Upper Sandusky, for outstanding postgraduate record; and five members, who each have fifty years in medicine were honored. These were Harry E. Chalker, M.D., Girard; Robert M. Lemmon, M.D., Akron; F. N. Nagel, M.D., Toledo; M. Dow Scholl, M.D., Chillicothe and Erhard Weltman, M.D., Youngstown.

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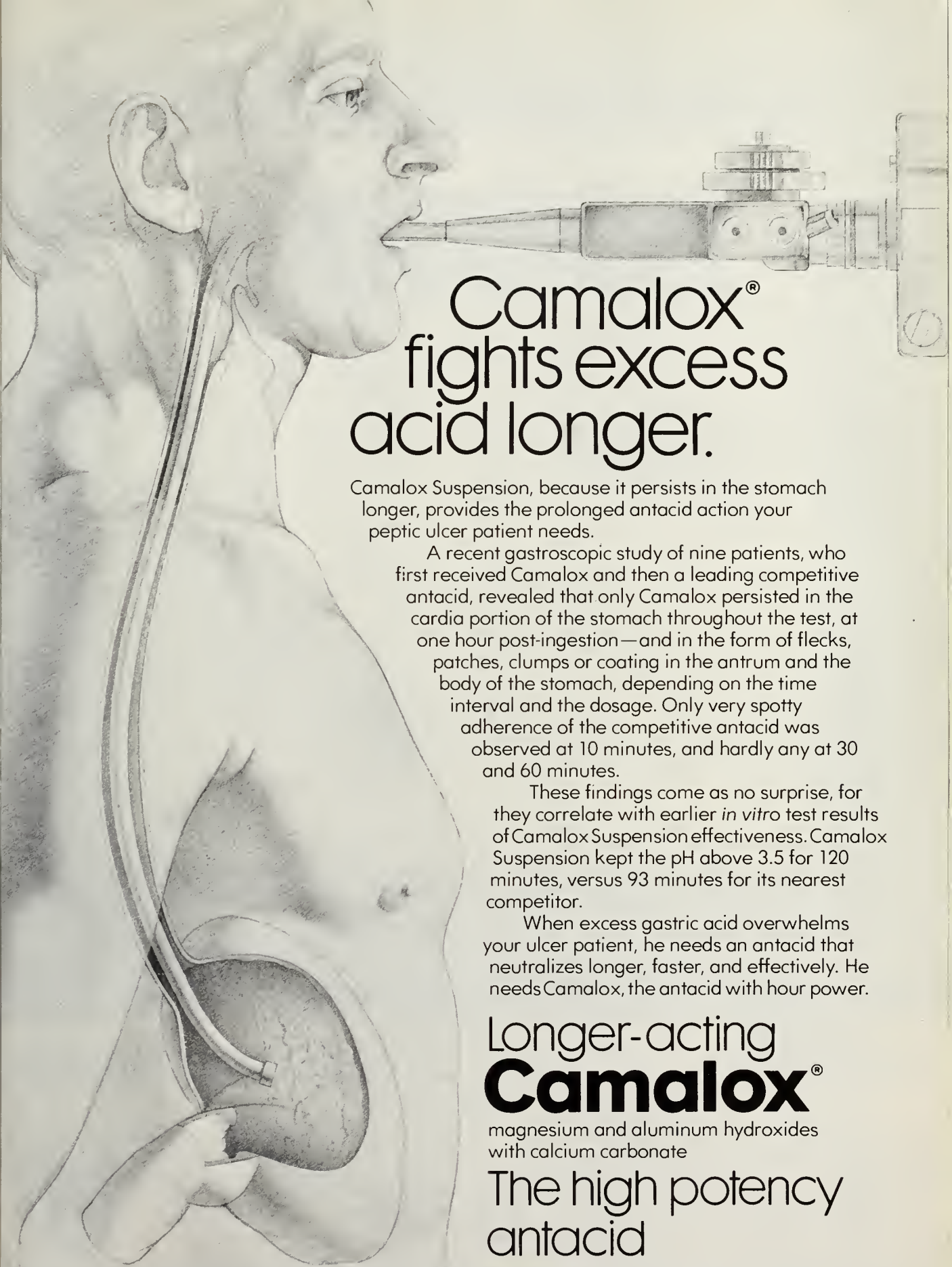
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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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Obituaries

Harry C. A. Beach, M.D., Columbus; Ohio State University College of Medicine, 1916; aged 88; died August 12; member of OSMA and AMA.

Stanhope B. Berkley, M.D., Lynchburg, Va.; formerly of Canton; Health Sciences Division of Virginia Commonwealth, 1913; aged 86; died August 13; member of OSMA.

William Hegley Bonser, M.D., Toledo; Duke University School of Medicine, 1939; aged 59; died August 3; member of OSMA and AMA.

William John Boswell, M.D., Huron; Ohio State University College of Medicine, 1952; aged 51; died August 7; member of OSMA and AMA.

Ernest Walter Garrett, M.D., Chagrin Falls; Western Reserve University School of Medicine, 1912; aged 88; died August 6; member of OSMA and AMA.

Jacob James Hoodlett, M.D., Lancaster; Hahnemann Medical College, Chicago, 1917; aged 82, died August 1; member of OSMA and AMA.

Joy Donald Huss, M.D., Toledo; St. Louis University School of Medicine, 1932; aged 68; died August 7; member of OSMA and AMA.

Earl Perry Knisely, M.D., Grove City; Ohio State University College of Medicine, 1939; aged 61; died July 30; member of OSMA and AMA.

John Laughlin McClintock, M.D., Alliance; Jefferson Medical College of Philadelphia, 1938; aged 61; died August 5; member of OSMA and AMA.

Max M. Pomerantz, M.D., Cleveland; New York Medical College, 1934; aged 65; died August 20; former member of OSMA and AMA.

Samuel Robert Salzman, M.D., Toledo; University of Illinois College of Medicine, 1909; aged 92; died August 14; member of OSMA and AMA.

Samuel Saslaw, M.D., Columbus; Ohio State University College of Medicine, 1946; aged 59; died August 22; member of OSMA and AMA.

John Harvey Skavlem, M.D., Cincinnati; Hahnemann Medical College of Philadelphia, 1919; aged 81; died August 7; member of OSMA and AMA.

Stewart J. Smith, M.D., Bowling Green; University of Michigan Medical School, 1933; aged 66; died August 3; member of OSMA and AMA.

Bruno Edwards Strauss, M.D., Dayton; University of Hamburg, 1938; aged 60; died July 27.

Harold Burdette Thomas, M.D., Chardon; University of Cincinnati College of Medicine, 1929; aged 73; died August 20; member of OSMA and AMA.

Hugh Cochran Thompson, M.D., Columbus; Ohio State University College of Medicine, 1928; aged 72; died June 19; member of OSMA and AMA.

Ben Widzer, M.D., Cleveland; Western Reserve University School of Medicine, 1934; aged 66; died August 25; member of OSMA and AMA.

John Kimber Williams, M.D., Wilmington; Ohio State University College of Medicine, 1950; aged 60; died August 1; member of OSMA and AMA.

Robert Morgenthaler Woolford, M.D., Cincinnati; Harvard Medical School, 1939; aged 59; died July 31; member of OSMA and AMA.

Oskars Zeidaks, M.D., Northfield; University of Latvia, 1936; aged 62; died July 29.



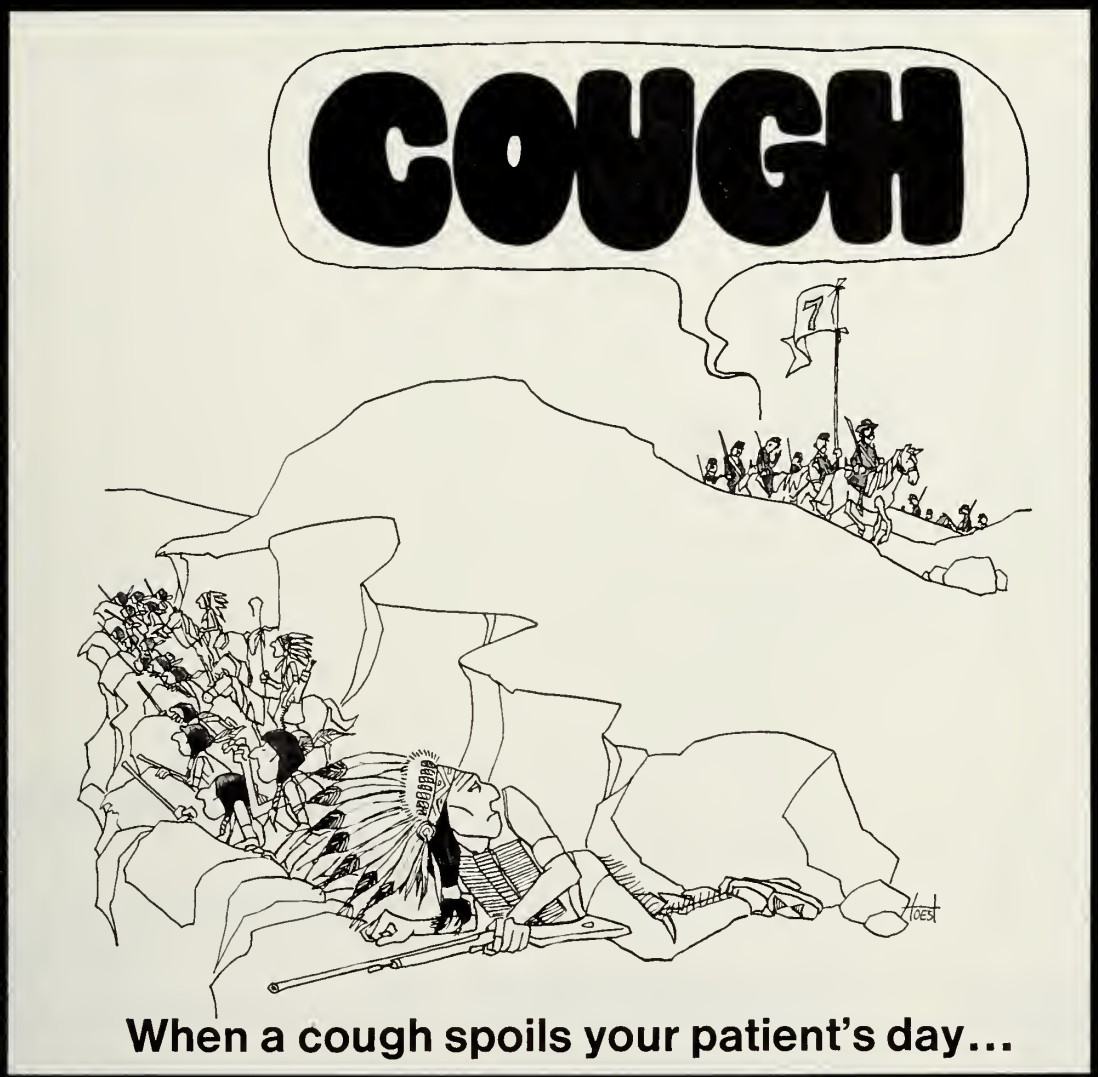
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Scioto County PG Seminar Scheduled For Oct. 24

The Scioto County Medical Society is sponsoring its Fifth Annual Postgraduate Medical Seminar on Thursday, October 24 from 1:00 to 8:30 p.m. The seminar, titled "Current Therapy V — Emergency Care, Office and Hospitality," includes a banquet and memorial lecture.

A summary of the program follows. For additional information, contact L. E. Thompson, Executive Secretary, 1805 27th Street, Portsmouth, Ohio 45662.

Seminar Chairman: Richard Villarreal, M.D.
Moderator: Sol Asch, M.D.

Problems in Treatment of Myocardial Infarction — Charles A. Bush, M.D., Assistant Professor of Medicine, Division of Cardiology, Ohio State University.

Emergency Treatment of Acute Psychoses— Ray H. Hayes, M.D., Clinical Associate Professor of Psychiatry, University of Louisville.

Trauma to the Abdomen — Ronald L. Krome, M.D., Associate Professor of Surgery, Wayne State University.

Emergency Management of Drug & Poison Overdose Problems — E. Don Nelson, Pharm.D., University of Cincinnati.

Shock and Trauma Management — Robert F. Wilson, M.D., Professor of Surgery, Wayne State University.

Acupuncture — *(Dr. Ralph W. Lewis Memorial Lecture)*—Edmund C. Casey, M.D., Assistant Professor of Medicine, University of Cincinnati; President Elect, Academy of Medicine of Cincinnati.

About $1.4 million is being returned to the federal government from sale of silver and mercury recovered from medical uses in the 171 Veterans Administration hospitals during the past year, the VA reported.

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CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
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In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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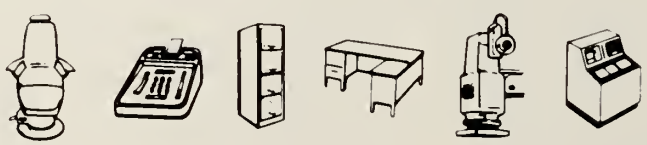
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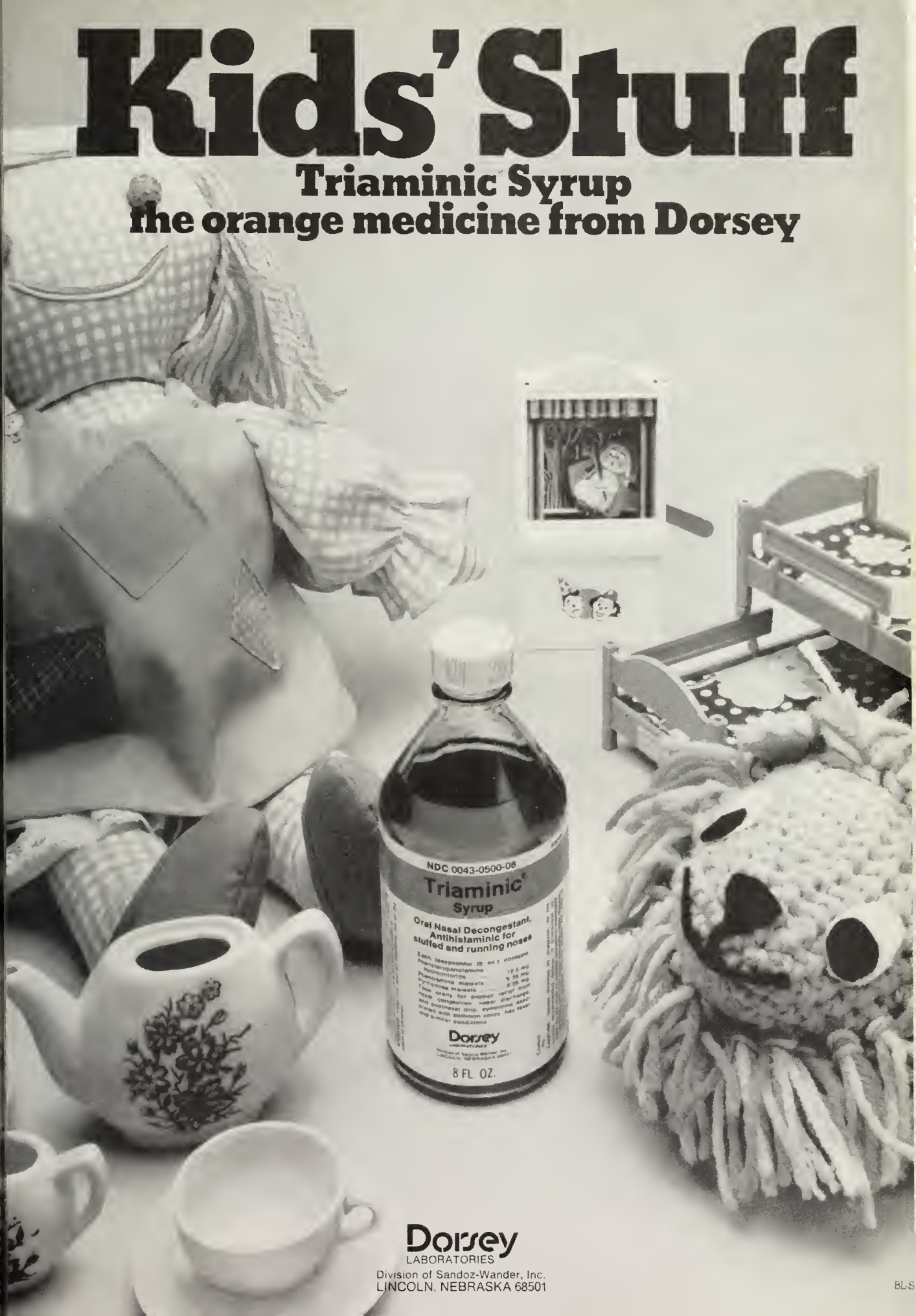


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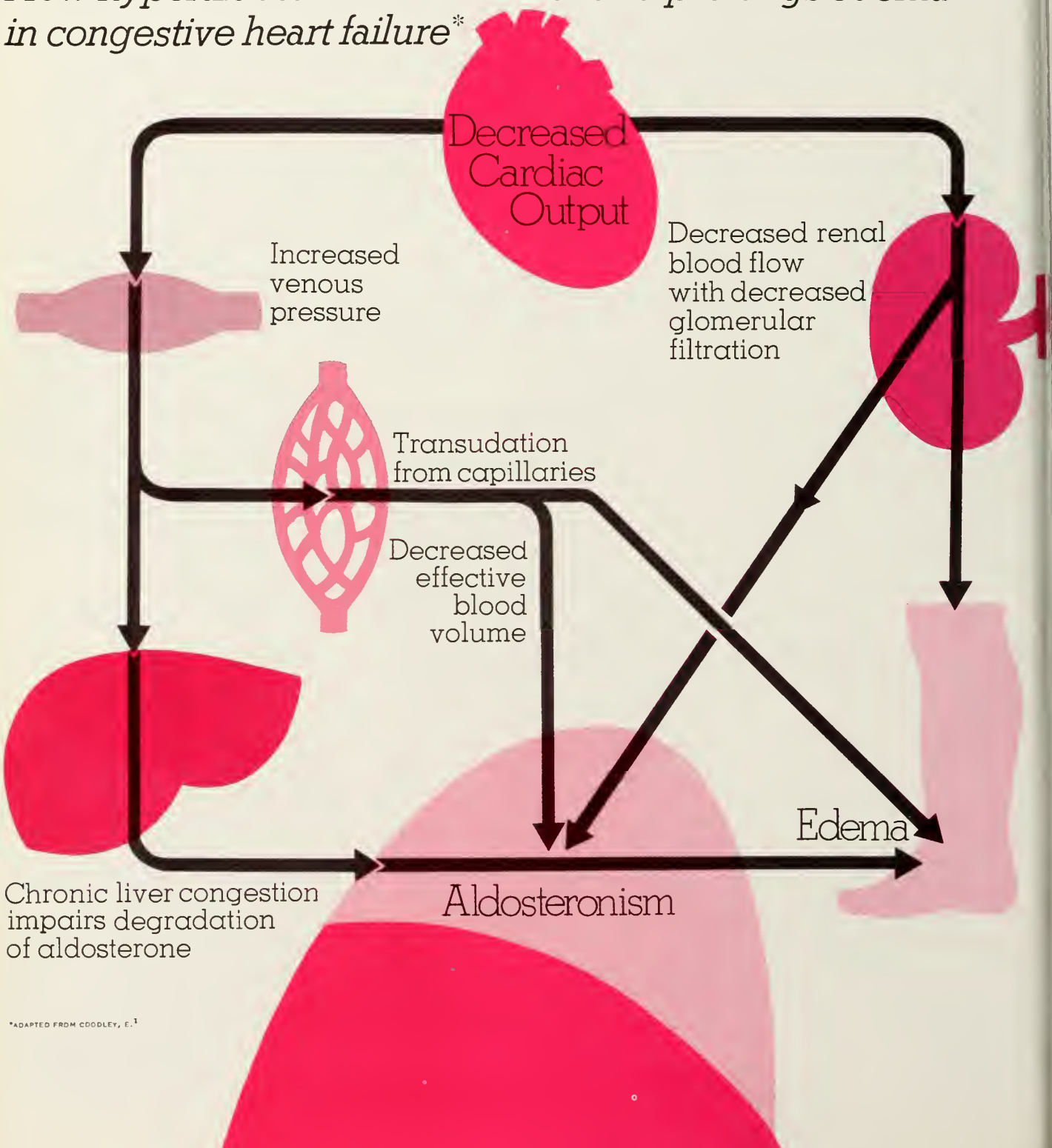
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- Avoids potassium loss.

2. As the basic daily diuretic with an "add-on" alternate-day-diuretic ("A.D.D." schedule)

- Can be administered daily as basic therapy with the additional agent (furosemide or ethacrynic acid) given every second or third day.
- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide

- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticoria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For **edema, ascites** or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Coadley, E.: Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Lauler, D. P.: Am. J. Med. 53:673-684 (Nov.) 1972.

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Opinion & Dialogue



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My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

s He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

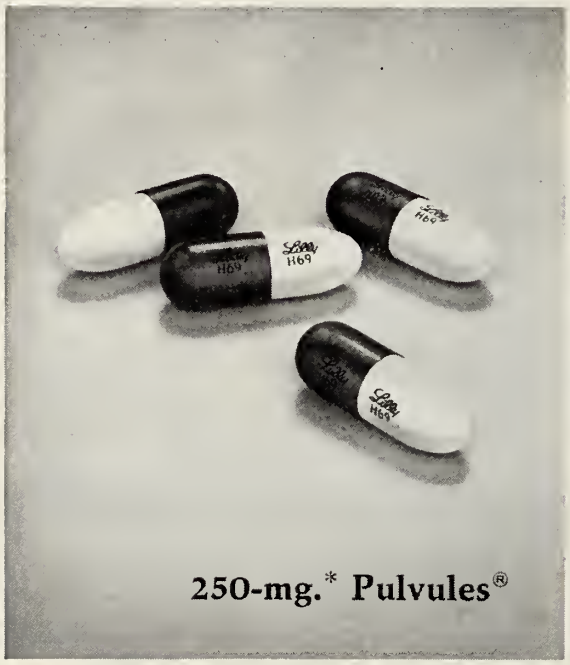
From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

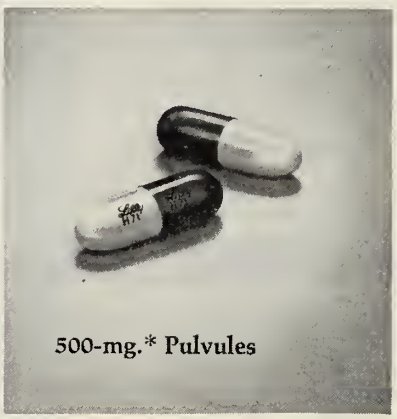
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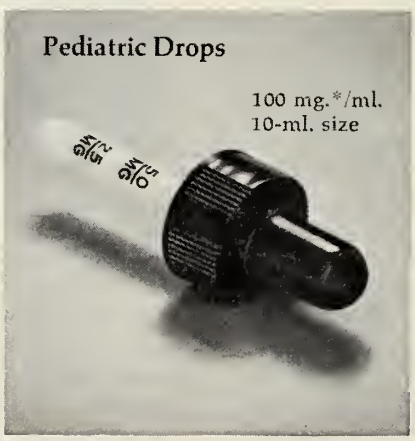
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Cervical Carcinoma In Situ at Akron General Medical Center

The Value of Colposcopy

William T. Yates, M.D.
William A. Cook, M.D.

CARCINOMA OF THE CERVIX is potentially a completely preventable disease. Since 1949, the incidence of invasive cervical carcinoma has decreased in the United States while the incidence of carcinoma in situ (CIS) has increased.[1] The incidence of CIS is highest in the age group 30 to 34 years reaching 13.38/10,000 females in that group. The peak is quite sharp: the incidence is lower in young girls and older women. A recent study of teenagers, however, revealed 16 cases of histologically proven CIS per 10,000.[2] Proper diagnosis and treatment of CIS and other cervical intra-epithelial neoplasms (CIN) results in virtually a 100 percent cure rate.

The Pap smear test has improved immensely the early detection of CIN. As early as 1943,[3] Papanicolaou and Traut demonstrated the effectiveness of cytology in the early diagnosis of cervical cancer. Following this, cytologic methods of early detection of CIN were further developed and refined. Slight, moderate, and severe dysplasia, and CIS were found to represent the continuum of CIN that can be detected by Pap smear. Richart and Barron[4] conducted a longitudinal study of 557 patients with various degrees of CIN as diagnosed by Pap smear and colpomicroscopy and found a progressive advancement in severity of all stages of CIN.

Colposcopy, introduced by Hinselmann in 1925, has been used routinely in large gynecologic clinics in Europe and South America for many years.[5] In recent years it has received increased attention in the United States, although effective resistance to it, as a "new technique," continues in most centers. More cases of CIN can be identified early, if colposcopy is used in combination with "routine" Pap smear or in the evaluation of any abnormal Pap smear on an annual or semi-annual basis. False-negative Pap smears, the major limitation of cytologic identification of CIN, occurs in up to 20 percent of routine smears.[6] Several studies, wherein colposcopy and Pap smear were used together, showed a range of false-negative Pap smears between 10.7 and 13.0 percent. Younge, et al.[7] using careful inspection of the cervix, found that CIS had an abnormal *gross* appearance in only 6 percent of cases. Yet experienced colposcopists routinely identify greater than 85 percent of CIS.

Colpomicroscopy is distinct from colposcopy. Colpomicroscopy is a research tool, time consuming, and exacting, in which the cervix is examined at magnifications up to 400X to allow identification of actual cellular detail. Colposcopy uses magnifications in the range of 10-40X, much like a dissecting microscope, to identify varying tissue and vascular patterns, in contrast to cellular patterns. The junction of squamous epithelium on the exocervix with columnar epithelium of the endocervical canal is the important area to examine because CIN of the cervix develops there. If the squamocolumnar junction cannot be visualized in its entirety, the colposcopy is unsatisfactory. The transformation zone, extending distally from this junction, can be described as typical or atypical. If atypical, directed biopsies are taken to evaluate the histology of the atypical epithelium of the transformation zone.

Blind biopsy has been used when an abnormal Pap smear is reported, or for obvious lesions. Staining of the cervix with Lugol's iodine or toluidine blue[8] has been used to select abnormal areas of the cervix for biopsy. The biopsy approaches are of value only if invasive carcinoma is found. Lesser

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Submitted May 21, 1974.

findings require conization. By contrast, colposcopically directed cervical biopsy obviates a conization of the cervix in 85 to 90 percent of cases. Endocervical curretage (ECC) is used, to rule out CIN, when the squamocolumnar junction is incompletely visualized. A positive ECC requires a conization to rule out invasive carcinoma. Definitive treatment of CIN is eradication of the lesion by hysterectomy, conization, electrocauterization, cryosurgery, or in toto biopsy—depending upon age and parity of the patient and the size and distribution of the lesion(s).

This paper reviews the methods of diagnosis and management of CIS at Akron General Medical Center for two years; May 1, 1972 to April 30, 1973, the year prior to the use of colposcopy, and May 1, 1973 to April 30, 1974, the first year of colposcopy use. This comparison was made to evaluate the role of colposcopy in the diagnosis and management of CIS.

Materials and Methods

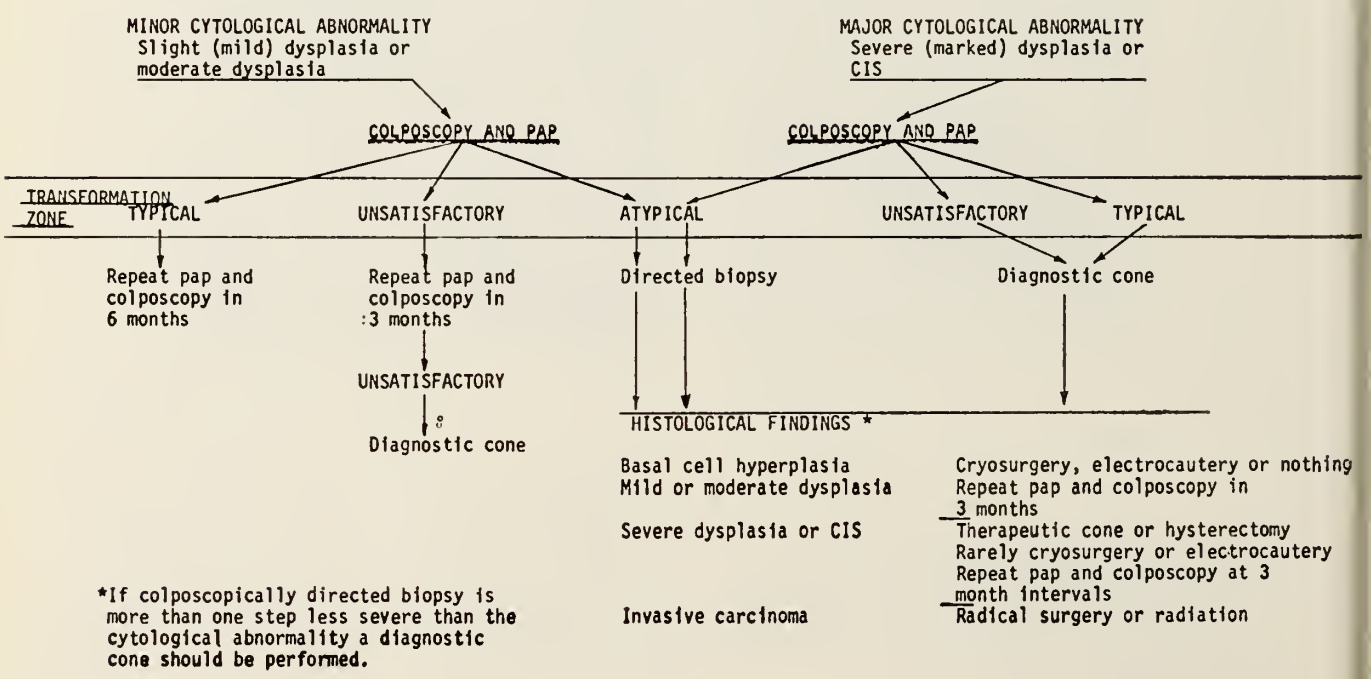
All patients with a histologically verified carcinoma in situ of the cervix, first diagnosed between May 1, 1972 and April 30, 1974, were included in this study. No independent pathologic assessment of the histologic sections was made. A diagnosis of CIS on the pathology report from our laboratory was the only requirement for inclusion in the study. The sample population was divided into two groups: those diagnosed up to April 30, 1973 and those diagnosed after May 1, 1973. A portion of the second group is fundamentally different in the diagnostic management because of the use of colposcopically directed biopsies. Each chart was reviewed for a report on previous Pap smears, diagnostic approach, treatment, and the presence or absence of residual neoplasm if treatment included hysterectomy. Information about Pap smears was obtained when necessary from the Akron General Medical Center cytology laboratory records and from staff office records.

Results

Thirty-five cases were identified in the first year and 43 cases in the second year. The age range in the first year was 21 to 70 years and the second year 22 to 65 years. The average ages of patients each year were 35.8 and 36.0 years. Cases under 30 years of age represented 16 of 35, or 46 percent, and 17 of 43, or 39 percent respectively.

Colposcopically directed biopsy was used in 12 out of 43 cases during the second year. In six of these 12, hysterectomy was performed without further evaluation. All hysterectomy specimens showed residual CIS. In four cases, the histologic diagnosis was CIS in both biopsy and hysterectomy specimens; in the other two colposcopic biopsies, the diagnosis was moderate dysplasia in one and severe dysplasia in the other, with CIS the finding in the hysterectomy specimen. Of the remaining

APPENDIX 1: WORKUP OF ABNORMAL PAP SMEARS AT AGMC



six patients, all had cold-knife conizations performed after colposcopically directed biopsies—two because results of Pap smears were suspicious and colposcopic biopsies were reported normal, two because of unsatisfactory colposcopy, and two in patients with positive colposcopic biopsy and positive ECC. All patients had CIS on conization and three of these had subsequent hysterectomy.

Cold-knife conization of the cervix was performed for diagnosis in 34 of 35 cases in the first year studied and in 32 of 43 cases in the second year. Hysterectomy was performed after these conizations in 29 of 34 and 18 of 32 cases respectively. Residual tumor in the hysterectomy specimen was found in 12 of 29 cases, or 41.4 percent, the first year and in two of 18 cases, or 11 percent, the second year.

Results of Pap smear tests prior to conization or colposcopy were available in all cases. Terminology for Pap smears is not completely consistent or specific. Here we will use positive, suspicious, and atypical as follows: positive means positive CIS, suspicious means severe dysplasia versus CIS, and atypical includes other dysplastic changes. The term "false negative" Pap smear is used in a clinical sense to include (1) sampling errors inherent in the exfoliative process, where normal cells may greatly outnumber neoplastic cells; (2) errors in taking the smear (eg 40 percent false negatives from the vaginal pool); and (3) Pap smears mistakenly interpreted as negative by the cytology laboratory. The table displays the breakdown of Pap smear abnormalities in these 78 histologically proven cases of CIS.

Discussion

Once identified histologically, the management of CIS is straightforward and effective. The management of dysplasias is more controversial. The management of invasive cervical carcinoma is an emotionally burdening, expensive, time-consuming, often tragic endeavor for both the physician and the patient. If colposcopy, in combination with the Pap smear, can lead to earlier diagnosis and, therefore, to lesions more easily treated, the technique should be used more extensively. (See Appendix 1.)

In this review, six patients with CIS were managed without conization. These six patients had only one hospitalization and one anesthetic—eliminating the average cost of hospital conization in the United States ($800.00). The family unit was spared the emotional cost of an added hospitalization. Colposcopically directed biopsy avoids the complications of conizations. Operative and postoperative bleeding, a problem in up to 30 percent of conizations in some series, does not occur with office biopsy. In pregnancy, conization has a very high risk of hemorrhage. Subsequent fetal loss approximates 15 percent.[6] Many people in the age group described here could be pregnant. An additional problem reported with conizations is failure of correct diagnosis if too few biopsy sections are prepared. Examinations of 15 sections will yield a diagnostic error 22 percent higher than if 80 sections are examined. Overall diagnostic error with conization is probably about 3.5 percent.[6] With colposcopically directed biopsy, the clinician gives the pathologist a smaller piece of tissue—but from an area of atypicality that usually cannot be identified grossly. The pathologist is then easily able to section the entire biopsy serially.

Results of Pap Smears in Histologically Proven CIS

Pap Smear Category	Percentage of Smears per Category 1972-1973	1973-1974	Combined
False negative	2.8	11.6	7.7
Atypical	34.3	25.6	29.5
Suspicious	28.6	30.2	29.5
Positive	34.3	32.6	33.3

The residual tumor in hysterectomy specimens following conization in the total group was 14 of 47, or 29.8 percent. This is a serious finding especially since conization is considered one method of definitive treatment of CIS. One criticism leveled at colposcopically directed biopsy is that the most serious area of the lesion may not be biopsied and, therefore, an invasive cervical carcinoma would be missed. On the contrary, colposcopy, by selecting areas of atypicality for biopsy, in contradistinction to gross conization and blind cervical biopsy, will be *less* likely to miss an invasive carcinoma. Invasive carcinoma will not be missed by colposcopically directed biopsy when the entire squamocolumnar junction is seen.

The distribution of Pap smears in the histologically proven CIS lesions is interesting. The false-negative rate of 7.7 percent is within an acceptable range. Yet it represents approximately 1,155 women, some of whom may have CIS, and others who may later present with invasive carcinoma. The evidence is clear and strong that colposcopy added to cytology can reduce the false-negative rate to near zero.[7] Fully 23 cases of CIS occurred in patients with mild, moderate, or occasionally severe dysplasia categories. These patients are usually managed by repeat Pap smear test in three to six months. In these patients, colposcopy can be especially useful. One patient followed in the Akron General Medical Center Clinic had three Pap smears showing moderate dysplasia over a period of six months. On colposcopy, an atypical area was biopsied and identified histologically as CIS. A conization followed to rule out invasive carcinoma because the entire squamocolumnar junction was not visualized. Only a small residual area of CIS was found. In another patient,

admitted for conization because of two moderate dysplasias (atypical Pap smear), routine colposcopy during work-up was suspicious for CIS and subsequently proven on conization. One of the patients had a false-negative Pap smear which was positive by colposcopic examination. A directed biopsy was positive for moderate dysplasia. Subsequent hysterectomy specimen showed CIS.

Summary

Two year's experience with CIS at Akron General Medical Center was reviewed revealing 78 histologically proven cases. The diagnostic and therapeutic management of these cases was reviewed and the following conclusions were reached: (1) Colposcopic evaluation of patients with abnormal Pap smears (positive, suspicious, atypical) may lead to earlier diagnosis and definitive treatment of cervical neoplasia; (2) Patients with a histologically proven CIS did not have positive or suspicious Pap smears in over 37 percent of cases in this study; (3) CIS is predominantly a disease of younger women with 42.3 percent in this study occurring in women under the age of 35 years; (4) No patients with invasive carcinoma of the cervix were missed by colposcopy; and (5) Cold-knife conization of the cervix did not eradicate CIS in 29.8 percent of patients as shown by residual CIS in hysterectomy specimens.

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Slipped Femoral Capital Epiphysis

David K. Halley, M.D.

SLIPPED FEMORAL CAPITAL epiphysis can lead to very serious disability involving the proximal femur and hip joint. It is frequently overlooked initially when the patient presents with symptoms involving either the hip or knee, because of a low index of suspicion, or inadequate roentgenograms, or misinterpreted roentgenograms. Early recognition is very important. Once slipping has occurred, its progression requires nothing more than trauma involved in everyday activities. The only security against further slipping is complete closure of the epiphysis.

Diagnosis

The diagnosis of slipped femoral capital epiphysis rests on a high index of suspicion. Certain known facts can lead to a higher level of suspicion. There is a male predilection of 2:1. The age range is between 6 and 17 years. Approximately 77 percent of the patients are overweight, with 25 percent manifesting characteristics of Fröhlich's syndrome.[1] Another group of patients present as tall, very thin, angular individuals.[2] In 20 to 25 percent of the cases, the contralateral hip is involved at some later date. Occasionally, both hips can be involved at the same time. Negroes are affected more often than whites.[3]

Clinical Findings

Clinically, the patient will complain of pain in the involved hip or thigh, or in over 50 per-

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Submitted April 8, 1974.

cent of the cases, the presenting symptom can be pain referred to the anterior thigh or knee.

A painful limp might be present. Frequently, because pain is sometimes referred to the knee. roentgenograms of the knee are taken and are interpreted as normal, and the hip abnormality is missed. Some children have been misdiagnosed as having flat feet, growing pains, or rheumatism.

In addition to discomfort, all patients will present with some loss of internal rotation of the involved hip. With careful observation, it can be noted the patient will tend to rotate the leg and foot externally while walking. This can be confirmed by examining the range of motion of the involved hip, which will demonstrate a decreased range of internal rotation.

Although the onset can be insidious, there is usually a history of trauma. The duration of symptoms prior to diagnosis can be quite variable but do bear a significant relationship to the degree of epiphyseal displacement.[1] Jacobs has demonstrated that with a slight slip (less than one-third the diameter of the femoral neck) the duration of symptoms averaged 13 weeks. With a moderate slip (less than one-half but greater than one-third the femoral neck diameter) symptoms averaged 24 weeks, while in a severe slip (greater than one-half the diameter the femoral neck) the average duration of symptoms was 40 weeks. The important thing to note here is that the slip can be minimal, but if not recognized early, what started out as a minimal slip can progress to a severe slip.

Roentgenographic Findings

Once a slipped capital femoral epiphysis is suspected, appropriate roentgenograms of the hip should be ordered in both anteroposterior and lateral views. The principal changes are:

1. Epiphyseal plate widened and irregular.
2. Loss of epiphyseal hump (Fig. 1).
3. Loss of capital epiphyseal height.
4. Inferior beaking of the capital epiphysis (Fig. 2).
5. Metaphyseal rarefaction.

Treatment

Once the diagnosis has been made, treatment is firm fixation of the epiphysis, either with pins or a bone graft.[4,5] Fixation should be maintained until closure of the epiphysis has been achieved. This usually requires six to nine months.

Treatment is guided by the classification of slipped capital femoral epiphysis.[6] If it is acute or gradual but less than one-third the diameter of the femoral neck diameter, fixation in situ can be achieved with threaded pins or a bone graft of the epiphysis.

If the slip is greater than one-third and gradual, fixation of the epiphysis is important.

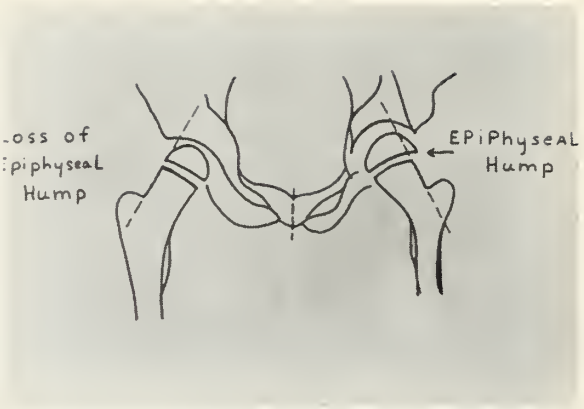


Fig. 1. Anteroposterior diagram indicates slight widening and irregularity of plate and loss of epiphyseal "hump."

Correction of the angular deformity is frequently required also. This usually requires a femoral neck or intertrochanteric corrective wedge osteotomy. If the slip is acute and greater than one-third the diameter of the femoral neck diameter, reduction is usually achieved by gentle, closed methods. Once reduction has been achieved, the epiphysis can be stabilized with the use of pin fixation as previously described.

Summary

Slipped femoral capital epiphysis can lead to potential serious hip disability when not recognized and treated early. This can be avoided by early diagnosis requiring a high index of suspicion. When a patient, usually a boy between 10 and 15 years old, complains of pain in his hip or knee and presents with the leg in slight external rotation, appropriate roentgenograms of the hip should be ordered. If there is loss of the epiphyseal hump

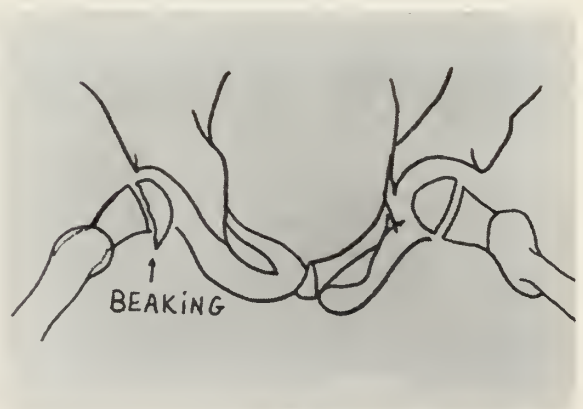


Fig. 2. Lateral diagram indicates slight breaking inferiorly and step-off superiorly.

or inferior beaking of the capital epiphysis, this is conclusive evidence of a slipped femoral capital epiphysis and treatment should begin immediately.

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Agenesis of Gallbladder

Case Report and Discussion

Henry W. Brown, M.D.
Elias M. Nicolas, M.D.
Madhira D. Ram, M.D.

AGENESIS OF THE GALLBLADDER is of interest to surgeons because it represents a diagnostic challenge, which until now could not be solved before surgery. This is a report of a patient with gallbladder agenesis and jaundice, in whom no stones were found at surgery. Less than 200 cases of this abnormality have been described in the literature.

Case Presentation

A 32-year-old white woman presented with dull epigastric pain radiating to the back associated with nausea but no vomiting. The complaints were of one year's duration. She also gave a history of intolerance to fatty food. Her other past history was noncontributory. She denied having any jaundice, acholic stools, or tea-colored urine. Physical examination revealed a well-built, obese female with epigastric tenderness but in no acute distress. Results of the remainder of the examination were normal.

Laboratory Data

Findings from chest x-ray film, intravenous pyelograph, barium enema, and upper gastrointestinal series were normal. The gallbladder was reported as non-visualized on two attempts. KUB film showed a questionable small, round density in the right upper quadrant, possibly representing a gallbladder calculus. Blood chemistry studies revealed serum cholesterol was 250 mg per 100 ml, total bilirubin 5 mg per 100 ml, direct bilirubin 3.5 mg per 100 ml, alkaline phosphatase 11 international units, serum glutamic oxaloacetic transaminase 20 units.

Hospital Course

On surgical exploration, the gallbladder was found to be absent. There was no evidence of a gallbladder impression on the under surface of the liver. The common bile duct contained no stones. Operative cholangiogram did not reveal an ectopic gallbladder. (See figure.) A #14 T tube was inserted, and the abdomen was closed. Postoperative course was smooth and uneventful. The pain disappeared, and the bilirubin dropped to a normal level. The patient was seen one month after discharge from the hospital and she had no complaints. The T tube was removed two weeks later and the patient is well and asymptomatic.

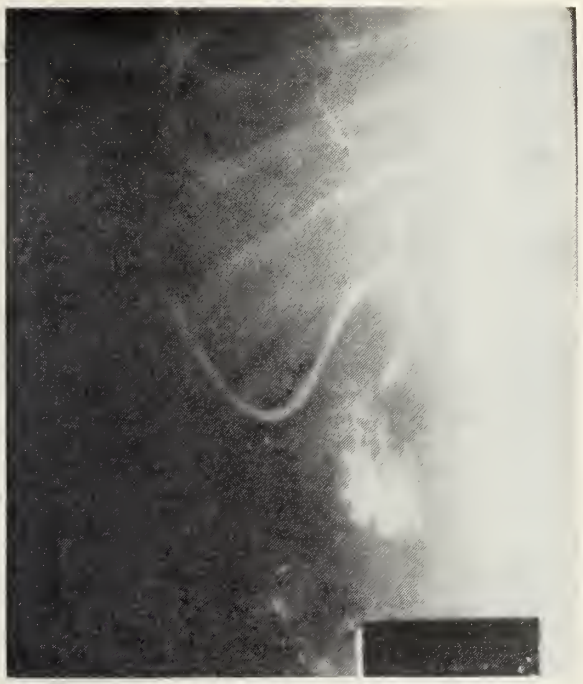
Discussion

Over 160 cases of congenital absence of the gallbladder have been reported in the literature. The incidence reported in autopsy studies ranges from 0.01 to 0.075 percent.[1] A review of 5,254 cases of biliary operations in Malmo General Hospital in Sweden revealed only two cases of absent gallbladder.[2] The gallbladder is thought to arise from the fetal gut as a bud. This bud is at first hollow but later transforms into a solid body due to epithelial proliferation. A third stage is a "hollowing" stage. Therefore, it was theorized that interference with either the budding process, or the "hollowing" process will cause agenesis of a gallbladder.[3]

Gross[4] mentioned that, in many cases of absence of the gallbladder, the patient also has occlusion of hepatic ducts and dies of jaundice a

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Submitted January 16, 1974.



Operative T-tube cholangiogram showing absence of gallbladder and no obstruction to the duct.

few months after birth. Among 200 cases of extrahepatic biliary atresia, 33 percent had absence of the gallbladder. When the gallbladder alone is absent, a good number of patients become symptomatic during the adult-to-middle-age period. Symptomatic patients may present with jaundice, right-upper-quadrant pain, or shoulder pain. Flannery[5] mentions that up to 50 percent of patients with absence of gallbladder were found at operation to have associated common bile duct stones. It was also mentioned that they could have stones without common bile duct dilatation or common bile duct dilatation with no stones. Our patient represents a third category, where we had a normal-sized common bile duct with jaundice. The only logical explanation would be that a stone was present, caused jaundice, and passed spontaneously.

A good number of patients pass their life asymptomatically, and the agenesis is discovered as an incidental finding at autopsy. Abnormalities of the liver are very rarely associated with gallbladder agenesis.

Agenesis of the gallbladder, though a rare disease, remains a challenge to the inquisitive mind and to the surgeon whose interest lies in an accurate preoperative diagnosis. Obviously the "clinical sense" is not going to help us in diagnosis of gallbladder agenesis. The answer to this riddle lies in better diagnostic technics and methods of visualizing the biliary tree, such as by cannulation of the common bile duct via the duodenoscope and by the awareness of the physician of the existence of such an entity as a "gallbladder agenesis." Before making the diagnosis, an aberrant location of the gallbladder should be excluded.[6] Operative cholangiography is still the best means available for making the diagnosis.

Summary

A 32-year-old white woman presented with a history of pain suggesting biliary disease. Investigations revealed a slightly elevated serum bilirubin, and the gallbladder was not visualized radiologically. At exploration, no gallbladder was found and the diagnosis of agenesis was confirmed by cholangiogram. This abnormality is very uncommon and the pertinent literature is briefly reviewed.

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Promiscuous behavior—

appears to be connected to disturbance in the mother-daughter relationship. The mothers, themselves unhappy, frustrated women, appear unable to give affection to their daughters. Lacking any sense of worth and hungry for affection, the girls readily trade themselves for affection or its symbolic substitutes (drugs, clothes, favors, etc.). Boys substitute for the mother in the girls' nurtural fantasies. Since positive feelings are lacking, adolescent rebelliousness takes on the character of an all-out war on "mother." Successful amelioration of promiscuous behavior seems to depend on the development of a more positive relationship between mother and daughter.—Daniel T. Gianturco, M.D., Durham, N.C.: *Southern Medical Journal,* 67:415-418, 1974.

Thermographic Demonstration of Tenosynovitis

A Case Report

Roger B. Traycoff, M.D.
Kenneth M. Malin, M.S.
Keith L. Ewing, Ph. D.
Bernard J. Rubal, M.S.

MOST CASES OF TENOSYNOVITIS of the hand displaying the typical rigid semiflexion of the digits and the tenderness, swelling, and erythema along the tendon sheath are not difficult to diagnose. However, acute gonococcal tenosynovitis may be difficult to differentiate from arthritis or periarthritis. Local tendon involvement with the absence of swelling and erythema tends to obscure the clinical separation. The purpose of this paper is to present a situation in which liquid crystal thermography (LCT) aided in the interpretation of one case diagnosed as presumptive gonococcal tenosynovitis.

Report of Case

A 21-year-old white woman was admitted to Akron General Medical Center with complaints of joint pain and a slight fever. She had no history of antecedent trauma. The tentative admission diagnosis was inflammatory arthritis.

The physical examination was unremarkable except for tenderness and swelling over the third and fourth metacarpophalangeal joints of the right hand with no overlying erythema. The patient described an acute onset of pain with swelling in her ring finger. The small and ring fingers were held in 30° of flexion, and extension produced severe pain. The fourth metacarpal head on the volar aspect was tender to palpation. The flexor tendons were not thickened and there was no obvious volar swelling. Although the localization of tenderness and swelling to the metacarpophalangeal joints suggested arthritis, the other general signs suggested tenosynovitis.

Upon questioning, it was noted that the onset of joint complaints coincided with the onset of menses. During the interview, she denied venereal exposure, previous musculoskeletal complaints, or dermal lesions. However, the record showed that approximately one week prior to admission she had experienced an episode of transient right-shoulder pain which lasted less than one day. She had been seen in a local emergency room where the diagnosis of bursitis was made and no treatment given. While denying venereal exposure she did volunteer that her husband had been involved in extramarital affairs and had been treated for a penile discharge within the month.

The erythrocyte sedimentation rate (Westergren) was 40 mm per hour, anti-streptolysin titer 50 Todd units, serum uric acid 2.2 mg per 100 ml, VDRL test for syphilis was nonreactive, antinuclear antibody (immunoflorescence-calf thymus) negative, and white blood cell count (WBC) 11,000 per cu mm with 70 percent band cells. Roentgenograms of the hands and shoulders were interpreted as normal. Cultures of the oropharynx, rectum, cervix, and blood, using Thayer-Martin medium,[1] were taken.

The patient was referred to the liquid crystal thermography laboratory where the authors were conducting a project investigating the efficacy of liquid crystal thermography in the differentiation of arthritic diseases. Temperature-sensitive cholesteric liquid crystals were applied to both hands using the technic of Davison, et al.[2,3] The color-temperature calibration was blue 34°C, green 33°C, red 32°C, and black less than 32°C. Prominent areas of elevated surface temperatures were noted on both the dorsal and volar surfaces of the right hand. There was no thermographic evidence of coexistent joint involvement. The thermogram was interpreted as being inconsistent with arthritis. The pattern suggested involvement of the ulnar flexor tendons including the common synovial sheath of the flexor digitorum superficialis and profundus muscles. The left hand was normal thermographically. The presumptive diagnosis of gonococcal tenosynovitis was made on the basis of onset with menses, history of venereal exposure, and thermographic confirmation of localized tendon involvement.

Treatment was initiated with crystalline penicillin G. On the following day, the patient was

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Messrs. Malin and Rubal, formerly of the Department of Biological Sciences, Kent State University, are currently enrolled in the College of Veterinary Medicine, The Ohio State University, Columbus, and Baylor University College of Medicine, Houston, respectively.

Dr. Ewing is Professor and Assistant Chairman, Department of Biological Sciences, Kent State University, Kent, Ohio.

Reprint requests to Department of Biological Sciences, Kent State University, Kent, Ohio 44242 (Dr. Ewing).

Submitted May 8, 1974.

afebrile and the WBC count was 5,000 per cu mm with 60 percent polymorphonuclear leukocytes. The pain had decreased markedly. All cultures were negative. Treatment was continued for ten days and she was discharged without residual. Upon discharge, she again was evaluated thermographically. At that time, the thermogram of both hands appeared entirely normal.

Discussion

Most cases of tensynovitis of the hand present little diagnostic difficulty and are identified readily by clinical examination. The fingers of the involved tendons are held in rigid semiflexion and the patient resists passive extension due to severe pain on motion. Tenderness can be outlined along the tendon sheaths, and the involved areas are frequently swollen with overlying erythema.[4,5] Commonly, there is either a history of trauma, repetitive unaccustomed use of the hands, or coexistent arthritis. There may be signs of systemic toxicity as manifested by rigors, fever, and leukocytosis.[6]

Gonococcal tenosynovitis generally resembles acute pyogenic tenosynovitis but tends to be less severe. There is usually a history of venereal exposure, concomitant arthritis, dermal lesions, or cervical discharge.[7] However, in early cases of tenosynovitis with only local tendon involvement, differentiation from arthritis or periarthritis may be difficult. Appropriate treatment may be delayed by incorrect diagnosis resulting in permanent damage and disfigurement.

In this case study, the interpretation of the liquid crystal thermogram supported the diagnosis of tenosynovitis. We suggest that thermography may be of clinical value as an adjunct to current diagnostic modalities in the identification and delineation of tenosynovitis thus insuring immediate and proper treatment.

Summary

In one case, ulnar flexor tenosynovitis was documented by liquid crystal thermography (LCT). Standard laboratory results indicated an inflammation. LCT was consistent with localized tenosynovitis rather than inflammatory arthritis or periarthritis. Penicillin G was administered early in the clinical course on the basis of history, examination, and thermography with a presumed diagnosis of gonococcal infection. Treatment was continued for ten days and the patient was discharged without residual. Liquid crystal thermography may serve as an adjunct modality in identification and delineation of early tenosynovitis.

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Small-airways function—

was measured by closing volumes in 40 patients after uncomplicated acute myocardial infarction who had no evidence of congestive heart failure by physical or radiologic examination. Mean value for closing volume was 125 percent predicted in 25 patients studied in the first two weeks after infarction as opposed to a mean value of 104 percent in 14 patients studied in the second two-week period after infarction ($p<0.01$). Seven patients with elevated closing volumes in the first two weeks after infarction had normal values when reevaluated four to 12 months later. Acute diuresis with furosemide reduced the elevated closing volumes to normal in two patients studied in the first week after infarction.

These findings suggest the occurrence, even in uncomplicated myocardial infarction, of transient left ventricular failure with pulmonary vascular congestion and transudation of fluid into the interstitial space, leading to premature airway closure. —Charles A. Hales, M.D., and Homayoun Kazemi, M.D., Boston: *The New England Journal of Medicine,* 290:761-765, 1974.

Professional Activities



AMA Clinical Convention in Portland Promises Excellent Features

THE 28th Clinical Convention of the American Medical Association is to be held in the Memorial Coliseum Complex in Portland, Oregon, from November 30 through December 4. This period includes the final business day deliberations of the AMA House of Delegates.

Dr. Huldrick Kamner, chairman of the Council on Scientific Assembly, said of this meeting: "In this age of specialization, there's a vital need for discussion of the broader implications of new-found knowledge. The 28th AMA Clinical Convention is designed for that purpose . . . to bring together physicians of the various specialties to study and discuss the broader aspects of medicine as they apply to their practices."

Scientific General Sessions will include discussions on human sexuality, hypertension, obesity, total parenteral nutrition (TPN), etc.

Postgraduate Courses include tumor chemotherapy, pulmonary function, blood gases, infections, diseases and antibiotics, basic and advanced electrocardiography, pediatric emergencies, office gynecology, immunization, and other topics.

The AMA always has a good film symposium, keeping physicians abreast of the latest developments in medicine and surgery and reviewing some of the procedures that are of current interest.

The AMA's Scientific Exhibit is a feature that few physicians would want to miss. Among special interest exhibits will be those on fractures, and cardiopulmonary resuscitation, with live teaching clinics playing an important role.

Special activities include a postgraduate course in public speaking on Saturday, November 30 and Sunday, December 1.

Another course on writing for scientific journals will be held on November 30.

The 16th national conference on medical aspects of sports also will be held on Saturday, November 30.

Registration forms are appearing in AMA publications. Registration for courses and luncheons should be in by October 21.

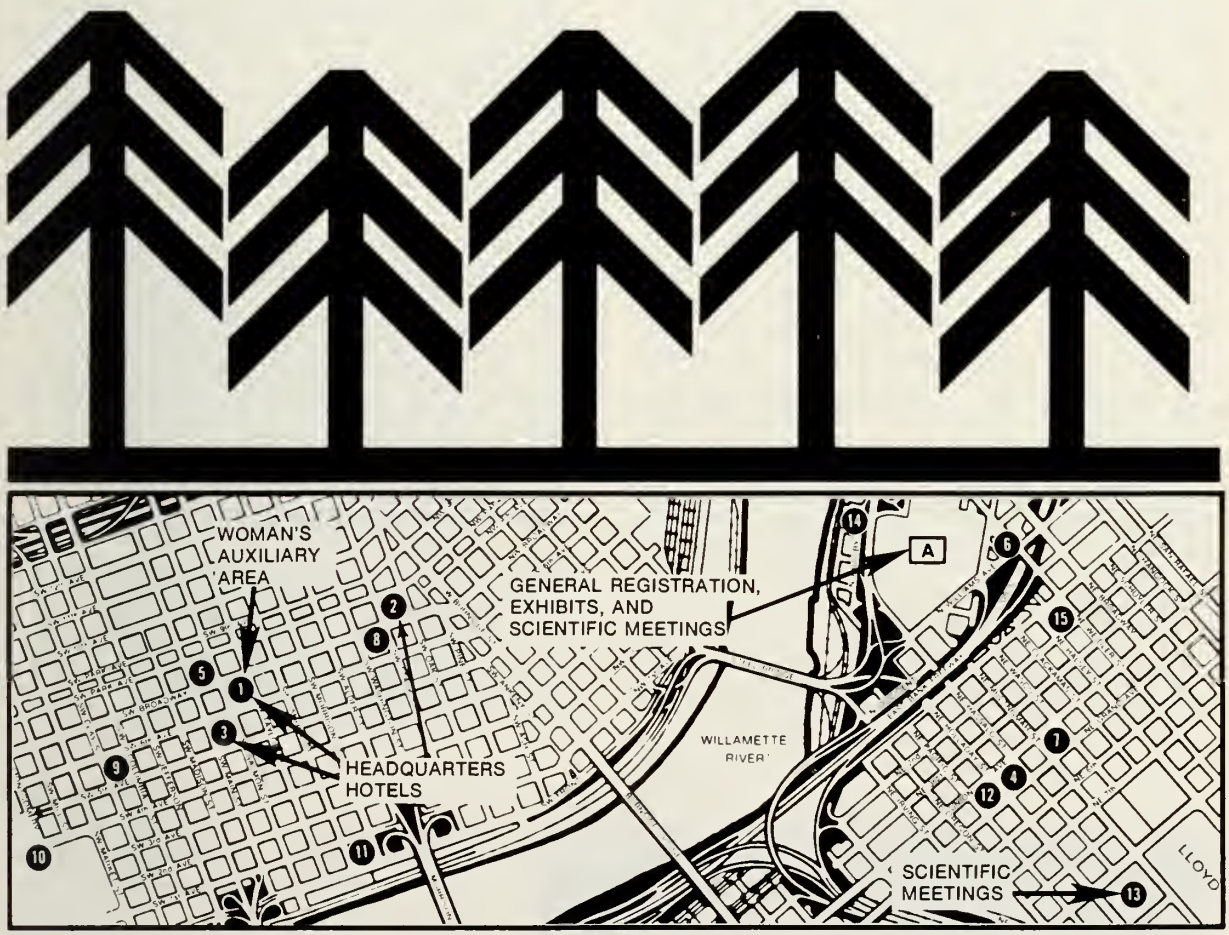
Sunday through Tuesday, round table discussions with luncheons are scheduled.

Housing should be reserved through the AMA Housing Bureau, in care of the Convention Bureau of Portland Chamber of Commerce, 824 Southwest 5th Avenue, Portland, Oregon 97204. Confirmations of housing will be mailed up to November 15.

Dr. Leon Goldman, director of the University of Cincinnati Laser Laboratory, and others associated with the unit, took prominent roles in a recent official "Laser Week for the Good of Man" show in San Diego, California. Exhibits were placed in several locations for public viewing, and the Cincinnati team was in charge of laser demonstrations in biology, medicine, art and music. The exhibit was sponsored by the Laser Institute of America.

Welcome to Portland, Oregon for the 28th Clinical Convention

November 30-December 4, 1974



"In this age of specialization, there's a vital need for discussion of the broader implications of new-found knowledge. The 28th AMA Clinical is designed for that purpose...to bring together physicians of the various specialties to study and discuss the broader aspects of medicine as they apply to their practices."

Huldrick Kammer, M.D., Chairman
Council on Scientific Assembly

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Awards Given at Physicians' Art Show Held in Cleveland

TOP HONORS at the Physicians' Art Show, a successful feature of the 1974 OSMA Annual Meeting, were given to Mrs. Ake Pereyma, Troy, for her ceramic sculpture titled "Black." Judges selected thirty-seven additional winners from the original art pieces on display. OSMA members and their wives or husbands from all parts of the state submitted entries.

Dr. Victor C. Laughlin headed the Art Committee of the Academy of Medicine of Cleveland in organizing and making arrangements for the show. Entries were divided into six categories: Paintings, oil; Paintings, acrylic; Paintings, watercolor; Sculpture; Photo-Arts; and Graphics and Crafts.

AWARDS

BEST IN SHOW: Mrs. Ake Pereyma, Troy, Ceramic Sculpture. "Black"

PAINTINGS, OIL
1st:—Mrs. Lee Hoffman (Gerard), Cleveland
2nd:—Mrs. Davita Sanchez, Lorain
3rd:—Mrs. Rosetta Volk, Shaker Heights
Honorable Mention:—William A. Kolozsi, M.D., Salem
Art Committee Awards
Robert Kirk, M.D., Cleveland
Paul C. Crone, M.D., Cleveland
Ralph J. Frackelton, M.D., Cleveland
Boris Marmolya, M.D., Cleveland
Mrs. Lyda Laughlin (Victor), Cleveland

PAINTINGS, ACRYLIC
1st:—Mrs. Lee Hoffman (Gerard), Cleveland
2nd:—Mrs. Barbara Smith (Earl), Shaker Heights
3rd:—Mrs. Evelyn Rosner (Robert), Cleveland
Honorable Mention:—Mrs. Ellen K. Coy, Cleveland

PAINTINGS, WATERCOLOR
1st:—Mrs. Ellen K. Coy
2nd:—Frank Meany, M.D., Cleveland
3rd:—Victor Laughlin, M.D., Cleveland
Honorable Mention:—C. Walker Munz, M.D., Cleveland
Art Committee Awards
George A. Streeter, M.D., E. Cleveland

SCULPTURE
1st:—Mrs. Aka Pereyma, Troy
2nd:—Milan Radivoyevitch, M.D., Cleveland
3rd:—Ralph Wolpaw, M.D., Cleveland
Art Committee Awards
Harold C. Klien, M.D., Cleveland

PHOTO-ARTS
1st:—Wolfgang W. Schubach, M.D., Cleveland
2nd:—Daniel S. Renner, M.D., Cleveland
3rd:—Tocky Run, M.D., East Cleveland
Honorable Mention:—Joseph Yared, M.D., Cleveland
Honorable Mention:—R. C. Waltz, M.D., Cleveland
Art Committee Awards
Harold Gold, M.D., Cleveland

GRAPHICS AND CRAFTS
1st:—Mrs. Marjorie Abel, Mount Vernon
2nd:—Mrs. Barbara Smith, Shaker Heights
3rd:—Mrs. Jo Tramer (Alvyn Weiss, M.D.), Cleveland
Honorable Mention:—Mrs. Fran Waltz, Cleveland
Art Committee Awards
Mrs. Audrey Heller (Grant), Shaker Heights
Mrs. Ethel Dindia (Anthony), University Heights
Mrs. Miriam Hait (Louis), Lorain
Kent Brown, M.D., Cleveland
Mrs. Helen Gerlach, Medina



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News Editor Named to Staff of Ohio State Medical Journal

DR. JAMES L. HENRY, OSMA President, has announced the appointment of Janis Tanner as News Editor and Assistant Business Manager of *The Ohio State Medical Journal,* effective September 1. She will be handling news and organizational material for *The Journal* as well as advertising and will have charge of make-up and arranging for printing by the contract print shop.

She will be working under the direction of the Executive Director and will take over many of the functions performed by Gordon Moore who is retiring after more than 26 years with *The Journal.*



Janis Tanner

Janis Tanner comes to the Columbus Headquarters Office from Peoria, Illinois, where she was Editor of PLAN Magazine, a publication of Caterpillar Tractor Company. Her education and background of experience has been varied and includes work and schooling overseas.

She is a graduate of Indiana University with majors in journalism and French, and was named to the Dean's List for academic excellence. Much of her high school studies were in Geneva, Switzerland, where her parents live, and while overseas she graduated from the International School of Geneva.

Practical experience while attending college included work as a reporter and writer for the Indiana University News Bureau and reporting for the Indiana Daily Student. Newspaper experience included a tour as reporter on the *Pekin (Illinois) Times.*

Mrs. Tanner, whose maiden name is Harrington, is a member of Sigma Delta Chi and Theta Sigma Chi, professional journalism fraternity and sorority, and Alpha Chi Omega, social sorority. While in College, she was a Panhellenic Rush Counselor, and a member of the Indiana University Student Foundation.

The new News Editor was recently married to Scott Tanner, third year student in the Ohio State University College of Dentistry.

In assuming her new duties, Janis will take over many of the responsibilities relating to the news about professional activities, organization functions, socioeconomic developments in the professional field, and so forth. She also will handle details pertaining to the placements of advertisements, makeup of *The Journal,* and relations with contract printers.

Mr. Moore came to *The Journal* position in January, 1948 after working as a reporter for the *Springfield News.* This was less than two years after he had completed a five-year tour of active duty with the Army during World War II. His military record included about two-and-a-half years in the Infantry and two-and-a-half years with the Reserve Officers Training Corps, his rank at separation being that of captain in the infantry.

He is a graduate of the Louisiana State University with a bachelor of arts degree in journalism and worked on both daily and weekly newspapers in Louisiana before the war.

At the 1973 OSMA Annual Meeting, Mr. and Mrs. Moore were honored before the House of Delegates and each was presented a watch as a gift of appreciation from the Association. Mr. Moore also was presented a handsomely engraved plaque which read as follows: "Presented to R. Gordon Moore, Executive Editor and Executive Business Manager of *The Ohio State Medical Journal,* in recognition of a quarter century of devoted service to the physicians of Ohio for the betterment of the Medical Profession, 1948-1973 — The Ohio State Medical Association."

During his years with *The Journal,* Mr. Moore has witnessed an increase of 38 percent in its circulation, from less than 8000 in 1948 to approximately 11,000 today. He also witnessed an

upsurge of size and scope of *The Journal* in the post-war period, matched by heavy support of pharmaceutical and other supply house advertising. (The unprecedented small size of recent issue of *The Journal* is due to a marked decline in support from advertising revenues, hopefully a temporary general trend in state medical journals.)



Betty and Gordon Moore as they were presented before the House of Delegates at the 1973 OSMA Annual Meeting. As Executive Editor of The Journal, he was presented an engraved plaque commemorating 25 years of service with the Association. Both were presented with watches on behalf of the Association by the President.

Mr. Moore is a member of Sigma Delta Chi, professional journalism society, a member of the Ohio Trade Association Executives, the American Association of Medical Society Executives, Civitan International, the Masonic Lodge and several Masonic affiliations. He is an Elder in the Overbrook Presbyterian Church and former member of its Session.

Mr. and Mrs. Moore are the parents of two children, and have two grandchildren. What does he plan to do after retirement? For one thing, he'll devote more time to his hobby of historical research and perhaps do some historical writing if his research efforts materialize.

"Anaerobic Infections" is a 20-minute sound film, No. 17 in the Upjohn Vanguard of Medicine series. For loan conditions write Upjohn Professional Film Library, 7000 Portage Rd., Kalamazoo, Mich. 49001.

The 1973 national highway death rate of 4.2 per 100 million miles of motor vehicle travel was the lowest in U.S. history, the Highway Users Federation reports. By way of comparison, the rate was 4.5 in 1972; 5.4 in 1963; 7.0 in 1953; 11.4 in 1943 and 15.6 in 1933. Ohio's 1973 rate was 3.6.

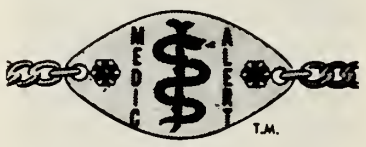
MEDIC ALERT Needs Public Interest To Save Lives

The Medic Alert Foundation International recently expressed concern about an apparent public unfamiliarity which deprives thousands of people of a life-saving emergency service.

The AMA estimates that 20 percent of all persons have some special medical condition that, if unknown or not immediately visible, can lead to tragic or even fatal mistakes in emergency medical treatment. About 500,000 such persons are protected by Medic Alert, a non-profit organization.

The program is simple — members wear a bracelet or neck disk imprinted on the front with the medical insignia and the words "Medic Alert." The reverse side is engraved with the person's specific medical condition or problem, his file number, and the telephone number of Medic Alert's Central File. Doctors, police, or anyone giving aid can get vital information by placing a collect call (24 hours a day) to the Central File.

Since Medic Alert relies greatly on physicians to inform patients about the program, free educational literature is provided. A pamphlet titled "This Could Save Your Life," containing the Medic Alert application form, is supplied with a



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To obtain free literature or further information, write to: Medic Alert Foundation International, Turlock, California 95380.

Woman's Auxiliary Highlights

Mrs. S. L. Meltzer, Communications Chairman
2442 Dorman Drive, Portsmouth 45662

IT IS SEPTEMBER and I am writing this in Maine and the leaves are turning into the vibrant reds and oranges and yellows of Fall. And as I write the word "Fall," I am caught up sharply by the realization that that lovely season of the year is virtually synonymous with the Auxiliary's October Conference, familiarly known as "Fall Conference." It is something of a teaching seminar, round-table discussion, and idea exchange rolled into one. It is get-together time for state officers and chairmen and county officers and chairmen. Not that it is restricted to officers and chairmen; quite the contrary — the general membership is cordially invited.

This year, the Conference will be held in the Hospitality Inn, State Route 161 at I-71 in North Columbus on October 23rd. Registration will begin at 8:30 a.m. and there will be coffee and rolls to revitalize the early travellers! But before I get into the outlining of the day's activities, I want to call attention to the state board meeting that will be held the previous day — October 22nd. That too will be held at Hospitality Inn and will open at 10:00 a.m. There will be a break for lunch and then more business-as-usual until 4:00 p.m. What is not business-as-usual this year is the general membership dinner at 6:00 p.m. at which Kent Hamdorf of Ohio State University will speak on "Parenting." And then a most interesting and important special program will challenge the group, a session on "Revising Our Bylaws." Mrs. Carl F. Schilling, state parliamentarian, will field the "How To" on the county level and Mrs. Louis Loria, state revisions chairman, will field questions about the proposed state revisions. It should all make for a lively discussion. . . . . .

The Fall Conference for 1974 is the joint responsibility of Mrs. S. J. Glueck, state president, and Mrs. Robert E. Krone, state president-elect. Co-chairmen for the Fall event are Mrs. William J. Donegan, Mrs. Thomas J. Williams and Mrs. Numan Yalaz, all of Clark County. There is something of a new twist to this year's set-up.

There will be seven "corner conferences" of one-half hour each (beginning at 9:25 a.m.) that will be repeated three times that morning. Each chairman will start her discussion at half hourly intervals with a five-minute break between. The smart thinking behind this new plan makes it possible for the county officers and chairmen to "cover" more sessions than had been possible in the past. They can choose the areas most important to them. They can move about freely and have the opportunity to "sample" with greater participation what is being offered.

These "corner conferences" will include AMA-ERF under the guidance of Mrs. Donald DeWald; Communications, Mrs. Samuel L. Meltzer; Community Health, Mrs. Kenneth Smith; Family Health, Mrs. Thomas Manning; Health Manpower, Mrs. Ernest Fox; International Health, Mrs. Armin Melior; and VD, Mrs. Herman Lubens and Mrs. Bingham. Also beginning at 9:25 a.m. and continuing to 11:05 a.m. will be the Mini-PAC course (in a different area of Hospitality Inn) that will be conducted by Mrs. Albert May, legislation chairman. The state treasurer, membership chairman and executive secretary will be available and "all over the place" to answer questions.

Luncheon-time will be 11:30 a.m. with district directors acting as hostesses. There will be a speaker — and he's a mighty good one! — H. William Porterfield, M.D., who will discuss "Current Medically Related Issues in the Legislature and Congress." And how badly we all need intelligent briefings on that!! The afternoon will highlight one important session — a miniconference on Health Education in the Schools with emphasis on curriculum planning. Mrs. S. Baird Pfahl, state health education chairman, will get that ball rolling at 1:30 p.m. with some terrific assistance from such outstanding experts as Robert Holland, chief of the Health, Physical Education and Recreation, Department of Education, State of Ohio; Linda B. Meeks, Department of Health Education, Ohio State University; and Mary Alice Beetham, also associated with the Department of Health Education at Ohio State University. A "model orientation" for auxiliary school representatives will be presented by members of the Erie County group. All of this adds up to what I am sure will be a particularly enlightening and helpful afternoon on a vital subject — health education.

So that Fran Krone and her committee can make for a more efficient and time-saving Fall Conference Day, advance registration are being

requested. Counties are being asked to indicate the sessions they plan to attend (our Auxiliary News will carry an enlarged advance reservation blank to be filled out and returned to Mrs. William Donegan). Among many other advantages, this advance registration will make it possible for last-minute adjustments in space assignments. Which, believe me, is no small matter to contend with! For those who would like to know the "how much" of it all, Tuesday night's dinner will be $8.00 per person and Wednesday's continental breakfast and the 11:30 a.m. luncheon will be $6.00 (inclusive). A block of rooms has been reserved at the Hospitality Inn for those planning to attend on Tuesday, the 22nd. Wednesday's programs have been set up to allow for a 3:30 p.m. adjournment and a daylight return back home.

I have said this many, many times before — and yet it always bears repeating (ad infinitum. I guess) — how important and "super" Fall Conference is. There is no one get-together during the year that offers more — in help, in stimulation, in friendship. County programs are already made up, to be sure. But Fall Conference charts the course that can be the most effective and meaningful. It really is "just what the doctor ordered"!!!

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Searle Laboratories, Division of G.D. Searle & Co. 620, 621

SK&F Co., Subsidiary of SmithKline Corporation 610

Turner & Shepard, Inc. 596

The Upjohn Company 600, 601

Wendt-Bristol Co. 602

Windsor Hospital 636

Wolman Insurance Agency, Inc. 614

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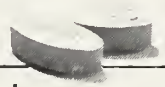
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The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

VOLUME 70 NOVEMBER 1974 NUMBER 11

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Original Articles

Pulmonary Angiography as an Aid to Resectability in Bronchogenic Carcinoma. F.L. Mendez, Jr., M.D.; Owen L. Brown, M.D.; and R.C. Rooney, M.D. 665

Cecal Mass Due to Intussuscepted Appendix. A Plea for Conservative Therapy. Ivan L. Shapiro, M.D., and H. Treat Caffetata, M.D. ... 671

Your AMA at Work

Doctor, Your Generous Contribution to AMA-ERF Is A Solid Investment in Medicine Future ... 678

Your State Society at Work

Testimony on Malpractice Insurance: OSMA Legal Counsel Appears Before Ohio Department of Insurance 656

What the OSMA Council Did at its September 20-22 Meeting 674

OSMA Appoints New Staff Member to Work with State Legislation 685

Report on Examination of Financial Statements for the Year Ended December 31, 1973 648

Former OSMA President Is Head of AMA Judicial Council 690

Keeping Up

Continuing Education Courses for Physicians Scheduled Throughout Ohio 660

Medical College Activities

Ohio State University Names New Chairman For Department of Surgery 700

Cincinnati University Establishes Family Practice Department 698

Public Health

Back to School Nuisance Diseases 646

Woman's Auxiliary

Immunization Action Month 702

The Journal

The Journal's Advertisers in This Issue 704

Classified Advertisements 705

Statement of Ownership 647

Other Features

New Members 662

Obituaries 696

MD's in the News 701

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



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in psychoneurotic anxiety states with associated depressive symptoms

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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VOL. 70 NOVEMBER, 1974 No. 11

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The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientifc and educational purposes.

Subscription, $5.00 per year to nonmembers; single copy, 50 cents (outside Continental U.S., $6.50 and 65 cents).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertiser must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

Medical Assistants Certified Through National Examination

The American Association of Medical Assistants has reported that 540 Certified Medical Assistant certificates — the highest number in history — were earned in June by those taking the annual certification tests.

Of this number, 21 were from Ohio — two receiving administrative certification, ten clinical, and nine a combination of administrative and clinical.

The nationwide number includes 23 who passed the new Pediatric examination offered for the first time this year. This program is conducted by AAMA in collaboration with the American Academy of Pediatrics.

Beginning in 1975, the examination will have a new format, consisting of the basic Certification Examination and three specialty examinations: Administrative, Clinical and Pediatrics.

The AAMA, a national organization of 15,500 medical assistants employed by physicians in their offices, offers the certification examination at more than 70 centers throughout the country. Information may be obtained from the American Association of Medical Assistants, One East Wacker Drive, Chicago, Illinois 60601.

Speed-Up Urged in Approving New Drugs

A speed-up in the procedure whereby new drugs are approved for use in the United States is urged in an editorial in a recent issue of the *Journal of the American Medical Association.*

Edward D. Fries, M.D., pointed out that several drugs now widely used in Britain to treat high blood pressure are not yet available to doctors in this country. Dr. Fries is senior medical investigator for the Veterans Administration Hospital in Washington, D.C.

New pharmaceutical products in the U.S. must be licensed by the U.S. Food and Drug Administration, which requires scientific proof of safety and effectiveness.

The editorial is companion to a report in the same issue of the Journal by a British physician on how British doctors treat high blood pressure. There are many points of similarity, but British doctors have available several drugs that have proved useful, but still are awaiting FDA approval in the United States.

Drugs in question are debrisoquine, bethanidine and propranolol. The first two are not available in the U.S. Propranolol is available, but is not approved for use in high blood pressure. Debrisoquine has been disapproved.

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Community Health News

Ohio Department of Health

JOHN H. ACKERMAN, M.D., Deputy Director

Back to School Nuisance Diseases

With the opening of school certain nuisance diseases are usually brought to the attention of physicians. Two of the most common nuisance diseases are head lice *(Pediculosis capitis)* and scabies *(Sarcoptes scabei)*. Even though these are two distinct clinical entities, they do have certain comman factors. Crowded conditions with little chance to bathe frequently and change clothing have led to large scale outbreaks of both diseases as seen most recently during World War II. With the advent of social order, the louse and scabies problem seemed again under control, but during the late 1960's through the present there has been a world wide resurgence of these two parasites. The exact cause of this resurgence is not known.

It is estimated that 5 to 10 percent of school children in the United Kingdom are infested with head lice. Little is currently known about the distribution of these parasites in the United States, however, numerous inquiries to the Ohio Department of Health indicate that they have become a real problem in Ohio over the past few years. Even though school has only been in session for one month, school districts in central and southern Ohio have reported scabies outbreaks. Neither of these parasites recognizes socioeconomic boundaries, but the course and distribution of the disease is influenced by crowding and socioeconomic status.

People of low socioeconomic status are more likely to have a chronic problem simply because they cannot afford to seek medical attention, buy pediculicides, or purchase a washing machine or clothes dryer, all of which contribute to the control of these parasites. With the congregation of chil-

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dren at school, any socioeconomic group is susceptible when exposed. Close personal contact is the usual mode of spread although transfer of the parasites through clothing is possible.

Scabies

Severe itching, which frequently worsens at night, is the chief symptom of scabies. Telltale burrows—flesh colored (sometimes erythematous) ridges—0.1 to 10 mm. long contain the mite. They usually appear between the finger webs, on the dorsal side of the wrist, and near the outer borders of the hands. Vesicles may also be present near the burrows. Other common sites are the elbows, axilla, waist, nipples, buttocks and penis. Diagnosis may be difficult because scratching may produce an eczemax-like condition or cause a secondary infection. The mite lives in the stratum corneum, which may be scraped and the mite identified from its burrow. The easiest and best method of treatment is the application of a 1 percent gamma benzene hexachloride cream or lotion (Kwell) over the entire body after an initial bath. This lotion should remain for 24 hours when another bath is taken. Machine washing the clothes will kill the scabies mite since they cannot survive temperatures higher than 120° for more than five minutes. For complete cure, the patient may need to repeat the bath-scabicide-bath regimen twice more at four day intervals.

Head Lice

Pediculosis is caused by a blood sucking louse. This organism has not been implicated in the spread of serious louse borne disease; however, in the laboratory it can easily be infected with the agent that causes louse borne typhus (R. prowazeki). The chief symptom of pediculosis is scalp itching. Diagnosis is usually made by the discovery of nits (lice eggs) attached to the base of a shaft of hair. Crawling forms may be hard to detect because they are small and in many infestations—only 10-20 organisms may be present on the scalp. Person to person contact is the main cause of disease spread but spread can also occur through garments such as hats and communal use of combs. These latter modes undoubtedly contribute to explosive school epidemics.

Temperatures of 125° F. will rapidly kill nits and adult forms within five minutes. These temperatures are easily reached in automatic washers and dryers and in dry cleaning processes, therefore, there is no need to destroy infested clothing or bedding. Many preparations are effective in destroying lice and their nits. As with scabies, a 1 percent gamma benzene hexachloride shampoo is a popular preparation for treatment. If a case is discovered in a school class probably the whole class should be examined for lice. All infected family members and/or classmates will need treatment if the infestation is to be stopped. Proper treatment of children should cause no more than 1-2 days absence from school.

OSMA's Continuing Education Physician Recognition Program To Appear In December Journal

The Journal will feature a special report in the December issue presenting the Ohio State Medical Association's Continuing Medical Education Physician Recogniton Program.

The report will describe the plan which OSMA wishes to develop and implement for accrediting institutions and organizations which offer continuing medical education programs.

A related article prepared by the Medical Advances Institute will also be published in the next issue.

Page 1

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1. TITLE OF PUBLICATION: The Ohio State Medical Journal
2. DATE OF FILING: September 20,1974
3. FREQUENCY OF ISSUE: Monthly
4. LOCATION OF KNOWN OFFICE OF PUBLICATION *(Street, city, county, state, ZIP code) (Not printers)*: 600 S. High Street, Columbus, Franklin County, Ohio 43215
5. LOCATION OF THE HEADQUARTERS OR GENERAL BUSINESS OFFICES OF THE PUBLISHERS *(Not printers)*: 600 S. High Street, Columbus, Franklin County, Ohio 43215
6. NAMES AND ADDRESSES OF PUBLISHER, EDITOR, AND MANAGING EDITOR

PUBLISHER *(Name and address)*: Ohio State Medical Association, 600 S. High Street, Columbus, Ohio 43215

EDITOR *(Name and address)*

MANAGER EDITOR *(Name and address)*: Mr. Hart F. Page, 600 S. High Street, Columbus, Ohio 43215

7. OWNER *(If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.)*

NAME	ADDRESS
Ohio State Medical Association A non-profit corporation with no stock outstanding.	600 S. High St., Columbus, Ohio 43215

8. KNOWN BONDHOLDERS, MORTGAGEES, AND OTHER SECURITY HOLDERS OWNING OR HOLDING 1 PERCENT OR MORE OF TOTAL AMOUNT OF BONDS, MORTGAGES OR OTHER SECURITIES *(If there are none, so state)*

NAME	ADDRESS
None	

9. FOR OPTIONAL COMPLETION BY PUBLISHERS MAILING AT THE REGULAR RATES (Section 132.121, Postal Service Manual)

39 U.S.C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates."

In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the reduced postage rates presently authorized by 39 U.S.C. 3626.

(Signature and title of editor, publisher, business manager, or owner)

10. FOR COMPLETION BY NONPROFIT ORGANIZATIONS AUTHORIZED TO MAIL AT SPECIAL RATES *(Section 132.122, Postal Manual)* *(Check one)*

The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes: ☒ Have not changed during preceding 12 months ☐ Have changed during preceding 12 months *(If changed, publisher must submit explanation of change with this statement.)*

11. EXTENT AND NATURE OF CIRCULATION	AVERAGE NO. COPIES EACH ISSUE DURING PRECEDING 12 MONTHS	ACTUAL NUMBER OF COPIES OF SINGLE ISSUE PUBLISHED NEAREST TO FILING DATE
A. TOTAL NO. COPIES PRINTED *(Net Press Run)*	11,170	11,350
B. PAID CIRCULATION 1. SALES THROUGH DEALERS AND CARRIERS, STREET VENDORS AND COUNTER SALES	2	2
2. MAIL SUBSCRIPTIONS	10,700	10,850
C. TOTAL PAID CIRCULATION	10,702	10,852
D. FREE DISTRIBUTION BY MAIL, CARRIER OR OTHER MEANS 1. SAMPLES, COMPLIMENTARY, AND OTHER FREE COPIES	300	312
2. COPIES DISTRIBUTED TO NEWS AGENTS, BUT NOT SOLD	0	0
E. TOTAL DISTRIBUTION *(Sum of C and D)*	11,002	11,164
F. OFFICE USE, LEFT-OVER, UNACCOUNTED, SPOILED AFTER PRINTING	168	186
G. TOTAL *(Sum of E & F—should equal net press run shown in A)*	11,170	11,350

I certify that the statements made by me above are correct and complete. *(Signature of editor, publisher, business manager, or owner)*: R. Gordon Moore, Executive Business Manager

PS Form 3526 July 1971

REPORT ON EXAMINATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED DECEMBER 31, 1973

ACCOUNTANTS' REPORT

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the balance sheet of Ohio State Medical Association at December 31, 1973 and the related statements of operations and net worth and changes in financial position for the year then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the aforementioned financial statements present fairly the financial position of Ohio State Medical Association at December 31, 1973 and the results of its operations and changes in financial position for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Columbus, Ohio
June 6, 1974

Coopers & Lybrand

OHIO STATE MEDICAL ASSOCIATION

BALANCE SHEET, December 31, 1973

ASSETS

Current assets:		
Cash, including time deposits of $96,398		$102,419
Accounts receivable, less allowance for doubtful accounts of $594		21,159
Accrued interest receivable		299
Prepaid expenses (including $42,300 of unamortized pension costs)		47,809
Total current assets		171,686
Other assets:		
Investments:		
General Trust Fund, at cost which approximates market	$ 28,844	
Ohio Medical Indemnity, Inc., at cost (Note 3)	56,000	
Unamortized pension costs, net of current portion (Note 1)	160,400	
Restricted time deposits (Note 2)	20,192	
Deposits	544	265,980
Property and equipment, at cost (Notes 1 and 2):		
Land	200,442	
Construction in progress, building	326,405	
Furniture and fixtures	63,775	
Less accumulated depreciation	(36,504)	554,118
		$991,784

LIABILITIES AND NET WORTH

Current liabilities:	
Construction loan payable (Note 2)	$315,077
Accounts payable	48,230
Total current liabilities	363,307
Deferred membership dues (Note 1)	93,815
Other deferred income	9,595
Net worth (Note 4)	525,067
	$991,784

(The accompanying notes are an integral part of the financial statements.)

OHIO STATE MEDICAL ASSOCIATION
STATEMENT OF OPERATIONS AND NET WORTH
for the year ended December 31, 1973

Income:		
Membership dues		$624,365
Exhibit fees		23,040
Annual meeting		6,374
Fees for collection of AMA dues		7,882
Interest on savings accounts and certificates of deposit		16,723
General Trust income		10,999
Other		2,616
		691,999
Operating expenses:		
Ohio State Medical Journal, net	$ 75,428	
Salaries	209,155	
Honorariums and expenses	67,546	
Professional conferences and scientific meetings	91,609	
Committee expenses	22,928	
Public relations	7,277	
Employee benefits, including pension costs of $42,300	67,279	
Contributions	12,382	
General operating expenses	149,405	703,009
Loss from operations (Note 4)		(11,010)
Net worth, beginning of year		536,077
Net worth, end of year		$525,067

STATEMENT OF CHANGES IN FINANCIAL POSITION
for the year ended December 31, 1973

Source of funds:	
From operations:	
Loss	$(11,010)
Depreciation and amortization not requiring working capital (including $42,300 relating to pension costs)	47,670
	36,660
Increase in deferred revenue	54,577
Decrease in unamortized pension cost, net of charges to operations not requiring working capital	13,900
Net book value of property and equipment sold	689
	105,826
Application of funds:	
Acquisition of property and equipment	348,341
Increase in General Trust Fund	10,999
Increase in restricted time deposits	20,192
	379,532
Decrease in working capital	$273,706
Changes in the components of working capital:	
Increase (decrease) in current assets:	
Cash	$ 33,022
Accounts receivable	9,540
Accrued interest receivable	(44)
Prepaid expenses and unamortized costs	15,372
	57,890
Increase in current liabilities:	
Construction loan payable	315,077
Accounts payable	16,519
	331,596
Decrease in working capital	$273,706

(continued)

(continued)

NOTES TO THE FINANCIAL STATEMENTS

1. Accounting Policies:

The following is a summary of certain significant accounting policies followed in the preparation of the financial statements. The policies conform to generally accepted accounting principles and have been consistently applied.

a. Depreciation:

The Association provides for depreciation on the straight-line and declining-balance methods in amounts adequate to amortize costs over the estimated useful lives of the assets. Depreciation charged to operations during 1973 was $5,370.

b. Deferred Membership Dues:

Income from annual membership dues is recognized in the calendar year to which they apply. Life membership dues income is recognized over 25 years of active practice of the life membership participants.

c. Prepaid Pension Costs:

At the inception of its qualified pension plan during 1969, the Association fully funded all costs of the plan, which amounted to $386,900. The prepaid costs are being amortized on an approved actuarial method each year, such annual provision consisting of normal cost plus 10% of the frozen initial liability (past service costs), reduced by interest on the unamortized prepaid costs.

2. Construction in Progress and Loan Commitments:

Subsequent to the purchase of property located at 600 South High Street, Columbus, Ohio, the Association contracted for the construction of a building for $467,312 upon this site. Both the land and building under construction are pledged as collateral to secure a construction loan commitment, at 8% amounting to $500,000.

The Association has capitalized the interest on the above construction loan in the amount of $6,239 for 1973. Such interest is charged to the construction in progress property account and will be amortized over the useful life of the asset.

Additional commitments pursuant to the construction loan agreement provide that upon the completion of construction, the mortgagee will make an unsecured loan of $300,000 at 1-1½% above prime to the Association, the entire proceeds of which shall be used towards payment of the construction loan to a $200,000 balance due. The unsecured loan (note payable to a bank) will be repaid in annual principal installments of $75,000.

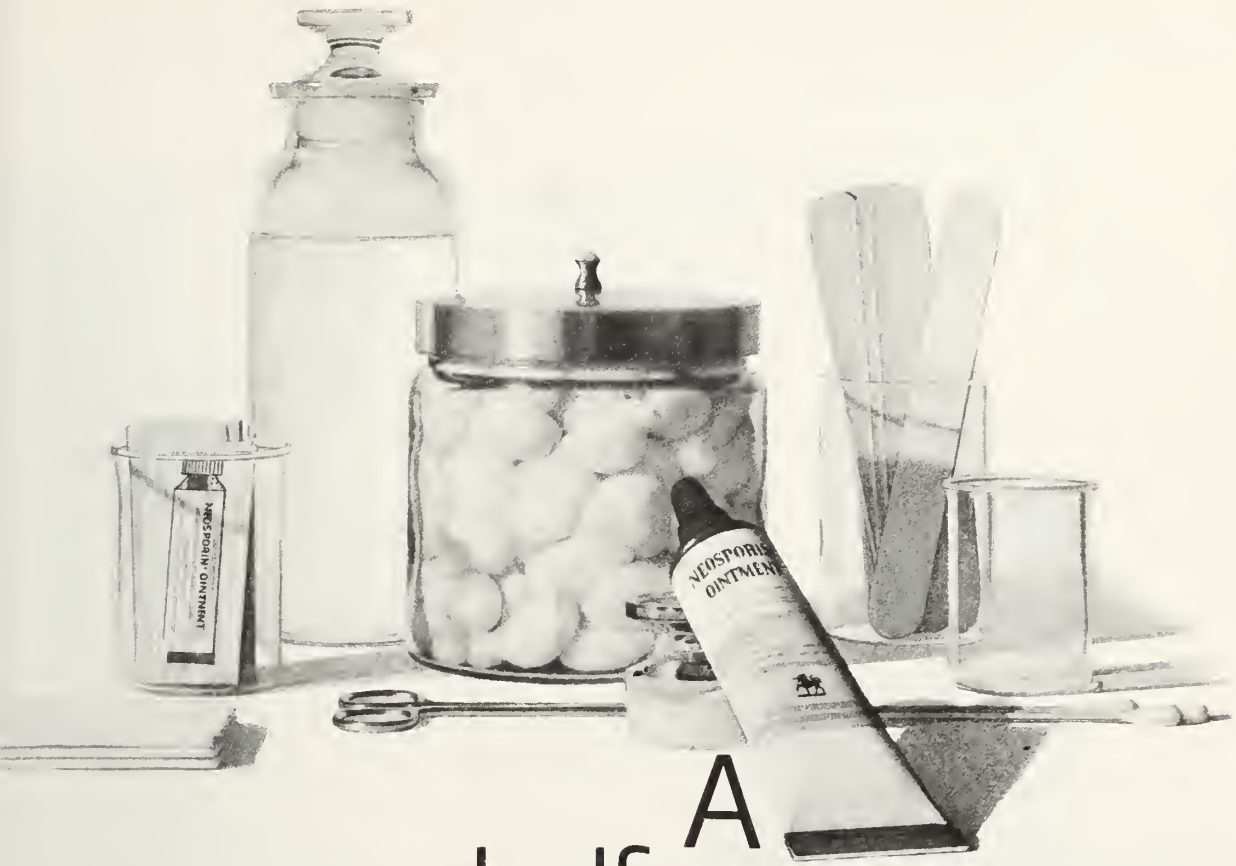
The construction loan agreement further provides that upon the completion of construction and the aforementioned payment towards the construction loan payable, the Ohio State Medical Association Pension Trust Fund will pay the construction loan balance due of $200,000 and thereby become the mortgage holder of such 8% loan balance due from the Association.

3. Investment — Ohio Medical Indemnity, Inc.:

The Association owns 100% of the outstanding common stock, 8,000 shares of Ohio Medical Indemnity, Inc. purchased at a cost of $56,000. The Board of Directors of Ohio Medical Indemnity, Inc. (Blue Shield) is prohibited from declaring or paying any cash dividends upon such common shares of stock of the Company. In the event of liquidation of the Company, the shareholder (Ohio State Medical Association) shall be paid a sum equal to the price paid for such shares, $56,000. The Company, having an equity of $36,750,000 at December 31, 1973, shall at liquidation distribute its remaining assets to the Association, or its successor organization, to be used solely and exclusively for medical research, medical education, or the development and establishment of medical care plans.

4. Exemption — Federal Taxes on Income:

The Ohio State Medical Association is exempt from federal taxes on income under Section 501(c)(6) of the Internal Revenue Code.



A half-ounce of prevention

Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

Neosporin Ointment carried on Apollo and Skylab missions.

Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs.
In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

TIONS: *Therapeutically,* used as an adjunct to appropriate systemic for topical infections, primary or secondary, due to susceptible organ- in: • infected burns, skin grafts, surgical incisions, otitis externa ry pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • second- nfected dermatoses (eczema, herpes, and seborrheic dermatitis) atic lesions, inflamed or suppurating as a result of bacterial infection. *hylactically,* the ointment may be used to prevent bacterial contamination , skin grafts, incisions, and other clean lesions. For abrasions, minor cuts nds accidentally incurred, its use may prevent the development of n and permit wound healing.

INDICATIONS: Not for use in the eyes or external ear canal if the eardrum rated. This product is contraindicated in those individuals who have ypersensitivity to any of the components.

G: Because of the potential hazard of nephrotoxicity and ototoxicity eomycin, care should be exercised when using this product in treating e burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

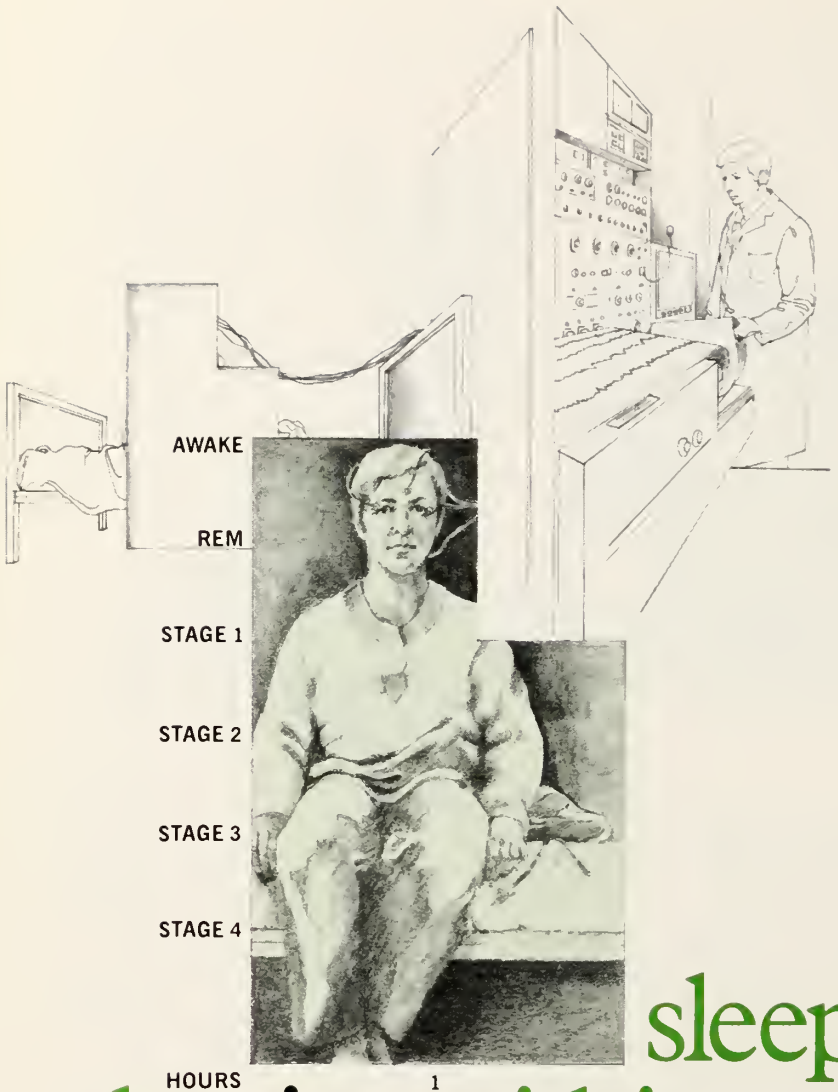
PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



sleep begins within 17 minutes, on average ...

an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]

Average Time Required to Fall Asleep (4 Studies, 16 Subjects[2-5])



(Decreased 42.6%)

Baseline (before **Dalmane**)

Dalmane (flurazepam HCl) 30 mg

confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

almane is generally well tolerated; morning "hang-over" has been relatively frequent. While dizziness, drowsiness, lightheadedness and the like have een noted most often, particularly in the elderly and debilitated, physicians hould be aware of the possibility of more serious reactions, as noted below.

efore prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, summary of which follows:

dications: Effective in all types of insomnia characterized by difficulty in falling asleep, equent nocturnal awakenings and/or early morning awakening; in patients with recurring somnia or poor sleeping habits; and in acute or chronic medical situations requiring restful eep. Since insomnia is often transient and intermittent, prolonged administration is generally ot necessary or recommended.

ontraindications: Known hypersensitivity to flurazepam HCl.

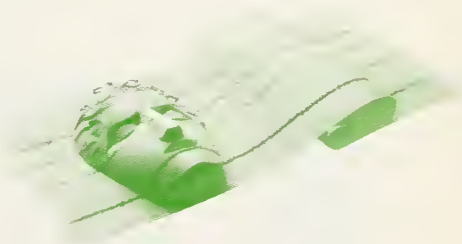
arnings: Caution patients about possible combined effects with alcohol and other CNS pressants. Caution against hazardous occupations requiring complete mental alertness g., operating machinery, driving). Use in women who are or may become pregnant only when tential benefits have been weighed against possible hazards. Not recommended for use in rsons under 15 years of age. Though physical and psychological dependence have not been ported on recommended doses, use caution in administering to ldiction-prone individuals or those who might increase dosage.

ecautions: In elderly and debilitated, initial dosage should be nited to 15 mg to preclude oversedation, dizziness and/or ataxia. combined with other drugs having hypnotic or CNS-depressant fects, consider potential additive effects. Employ usual precautions patients who are severely depressed, or with latent depression or icidal tendencies. Periodic blood counts and liver and kidney nction tests are advised during repeated therapy. Observe usual ecautions in presence of impaired renal or hepatic function.

dverse Reactions: Dizziness, drowsiness, lightheadedness, ggering, ataxia and falling have occurred, particularly in elderly debilitated patients. Severe sedation, lethargy, disorientation and ma, probably indicative of drug intolerance or overdosage, have en reported. Also reported were headache, heartburn, upset omach, nausea, vomiting, diarrhea, constipation, GI pain, nervous- ss, talkativeness, apprehension, irritability, weakness, palpitations, est pains, body and joint pains and GU complaints. There have so been rare occurrences of sweating, flushes, difficulty in focusing, urred vision, burning eyes, faintness, hypotension, shortness of eath, pruritus, skin rash, dry mouth, bitter taste, excessive saliva- n, anorexia, euphoria, depression, slurred speech, confusion, stlessness, hallucinations, and elevated SGOT, SGPT, total and rect bilirubins and alkaline phosphatase. Paradoxical reactions, g., excitement, stimulation and hyperactivity, have also been ported in rare instances.

osage: Individualize for maximum beneficial effect. *Adults:* 30 mg ual dosage; 15 mg may suffice in some patients. *Elderly or debil- ated patients:* 15 mg initially until response is determined.

pplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- **induces sleep within 17 minutes, on average**
- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

EFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry* 23:226-232, Sep 1970
Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and eep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric ssociation, Washington DC, May 3-7, 1971
Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Opinion & Dialogue

The Role of the Detail Man

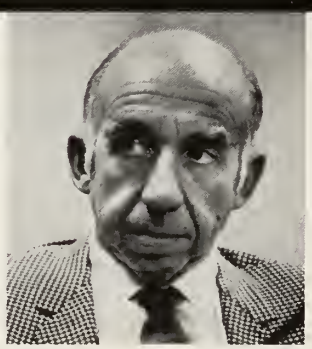


Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I ar very much in favor of the detail me I meet. Most of them are knowledg able about the drugs they promote and can be a great help in acquain ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealin with health problems in this count there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of con tact that people in a medical cente research people, and academic people have and that's in all likelih on a somewhat different level from that of the practicing physician.

Let me touch on how I person ally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real edu cational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent film produced by the pharmaceutical industry. When they function in th

s He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

raining of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

apacity they are indeed useful; articularly in the fact that they isseminate broadly based educaonal material and serve not just s "pushers" of their drugs.

he Other Side of the Coin

Obviously, the pharmaceutial companies are not producing all is material as a labor of love—ey are in the business of selling oducts for profit. In this regard e ambitious and improperly motited sales representative can ert a negative influence on the acticing physician, both by prenting a one-sided picture of his oduct, and by encouraging the actitioner to depend too heavily drugs for his total therapy. In ese ways, the salesman has often storted objective reality and ndermined his potential role as an lucator.

he Industry Responsibility

Since the detail man must be information resource as well as representative of his particular harmaceutical company, he ould be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

Testimony on Malpractice Insurance

OSMA Legal Counsel Appears Before Ohio Department of Insurance; Legislation Proposed to Alleviate the Physician's Dilemma

THE Ohio State Medical Association's Legal Counsel, James E. Pohlman, on September 18 appeared before a factfinding-hearing of the Ohio Department of Insurance to present testimony on the rising costs of medical malpractice insurance. In his testimony, he documented the increasing cost of malpractice insurance, and called attention to the Hearing Officers to two pieces of legislation sponsored by the State Association.

TESTIMONY

By James E. Pohlman, LL. B.

My name is James Pohlman. I am a member of the Columbus law firm of Wright, Harlor, Morris & Arnold and I am appearing today on behalf of our client, Ohio State Medical Association.

The Ohio State Medical Association welcomes this opportunity not only to contribute its views to this important hearing but also to listen and learn from the other witnesses who have been invited to attend. Needless to say, the medical profession is always interested to learn more about medical malpractice, both as it relates to the quality of the medical care rendered by it to the citizens of Ohio and also as it relates to the ultimate cost of such care.

The questions propounded by the Department of Insurance in its letter of invitation suggests, to me at least, that there are two underlying concerns being expressed:

1. Is the traditional tort system for resolving medical malpractice disputes viable today when subjected to a "cost-benefit" analysis? Or, to put it differently, is the present tort system providing to the consumers, i.e., the patients, benefits which are commensurate with the costs of the system?

2. If not, what alternatives are there to the present tort system?

The medical profession generally and the Ohio State Medical Association in particular have long shared these concerns and, as I will point out a little later, have undertaken positive programs to deal with certain of these issues.

With enactment of P. L. 92-603, federal legislation now mandates the establishment of Professional Standard Review Organizations designed to establish standards and parameters of quality health care. While it is hard to know at this point what the eventual impact of P. L. 92-603 and the Professional Standard Review Organizations created under the law will be upon the medical malpractice situation, physicians are hopeful that one of the benefits will be to ensure that a physician could adhere to appropriate medical standards without fear of civil liability and without practicing "defensive medicine" which everyone recognizes adds further cost burdens to the system. The classic example of "defensive medicine" is, of course, the over utilization of diagnostic x-rays, often ordered by the physician because of his concern of a possible malpractice claim.

The Ohio State Medical Association has, as many people in this room are aware, long made positive commitments to quality health care for the people of Ohio. Long before Congress enacted P. L. 92-603, the Ohio State Medical Association, through its affiliate organization, Medical Advances Institute, was engaged in extensive research and development efforts to develop medical criteria, readily adaptable for computer use, for assuring high standards of quality medical care for the citizens of Ohio. These efforts continue and the results of MAI's national leadership in this area will continue to place Ohio in the forefront of those areas which will benefit from these advancements in medicine and technology.

Consistent with this strong commitment to the delivery of quality medical care to the citizens of Ohio, the leaders and membership of OSMA remain committed to the basic premise underlying our present tort system: that patients who are injured and suffer damages as a result of acts or omissions of the doctor which are not consistent with good medical practice should receive promptly reasonable and fair compensation. We recognize, of course, that this system of tort law is, in the era of "no fault" automobile insurance and "no fault" divorce, under attack and that many people are urging that other systems of compensating accident victims be instituted. We leave aside today, however, any discussion of the philosophical arguments in support of or in opposition to either our traditional "fault" system or the innovative "no fault" proposals in favor of a closer look at the present tort system.

Physicians, of course, carry a professional liability insurance to insure against the risk of civil liability under our present tort system and

it is a truism to repeat that the cost to physicians of such professional liability insurance has risen sharply in recent years in Ohio. (See Exhibit A attached.) (The following tabulation is presented in support.)

Physicians are not insurance experts, and they must rely upon the insurance industry and the Department of Insurance to insure that professional liability insurance is not only available to them but offered at fair and reasonable premiums. OSMA notes with interest that an investigation is apparently now being undertaken by the Department to determine whether such is indeed the situation.

While we are willing to co-operate with the Department in any way in this fact-finding investigation, OSMA does not have the data and statistical and underwriting information available to it necessary to make such an investigation and determination, but we assume that the Department has or is able to gather such information under its regulatory authority. The Department is, I am sure, fully familiar with the results of the various national investigations such as the Ribicoff Report and the Report of the Secretary's Commission on Medical Malpractice and such statewide investigations as the California State Assembly Select Committee on Medical Malpractice. In that regard, we know of no unusual local situations existing in Ohio which would make those reports inapplicable to your study.

In answer to the question as to why the premiums paid by physicians for professional liability insurance have risen so rapidly, the obvious response is that the **number** of medical malpractice claims has increased sharply in recent years and that the amount of jury verdicts and settlements and other costs necessary to dispose of the claims has also increased sharply at the same time. The underlying causes behind that rather superficial answer are, however, considerably harder to isolate and prove, but a consensus of the members of the medical profession would probably identify the following "root" causes: rising inflation; increased media attention to the victims of all accidents, including medical accidents; rising expectations in terms of the results of medical care; more litigious attitudes by members of the public; abuses of the contingent fee system; and recent trends in the substantive and procedural law that have tended to favor the patients and their lawyers in medical malpractice litigation.

Some of these underlying causes, of course, apply to the tort system generally and are not unique to the medical malpractice situation, but I would like to discuss briefly the one matter which is unique — that of the recent developments in the substantive and procedural law which, in my judgment at least, clearly favor the patients in the prosecution of their claims against the physicians.

One development is the well known doctrine of "informed consent." One recent law review article begins with the comment: "The doctrine of 'informed consent' has achieved a status in the law of medical malpractice unmatched both in speed of growth and bulk of commentary."

Let me state clearly that the members of the medical profession are keenly aware of the need to inform their patients about the diagnostic procedures and the therapeutic measures that they undertake in the course of treating their patients. The obligation placed upon the physician to make such disclosures is not only good law, it is good medicine. However, the report of the Secretary's Commission on Medical Malpractice noted that the doctrine of informed consent is clearly subject to abuse. To quote from the report: "The Commission FINDS that the doctrine of informed-consent is subject to abuse when it imposes an unreasonable responsibility upon the physician." There is not much question in my mind but that the doctrine is being abused in Ohio.

A trial lawyer in Cleveland told me some time ago, only somewhat facetiously, that the frequency of informed consent claims in medical malpractice litigation in Cleveland had reached such high levels that he believed that any lawyer representing a patient who did not include a claim of informed consent in a **medical** malpractice case was himself committing **legal** malpractice. My own trial experience in Columbus tells me that the doctrine is being indiscriminately used by patients and their lawyers here.

One of the unfortunate aspects of the increased, if not universal, reliance upon the doctrine of informed consent by plaintiff's lawyers is the fact that the claim is always asserted in the face of a bad result and with 20-20 hindsight. I have never heard of anyone claiming after a **good medical result** has been achieved that the doctor did not adequately inform the patient of the hazards and risks of the procedure. Given the **bad medical result** and the desire to seek compensation from the physician who performed the procedure (which may or may not have caused the poor medical result), it is not surprising that these cases frequently are reduced to what trial lawyers call "swearing matches."

The patient "swears," on the one hand, that the physician failed to give a proper disclosure of the hazards and risks of the procedure and the physician "swears" on the other hand that, while he does not recall his conversation specifically with the patient (since he saw many others that day several years ago when the treatment was performed), he nevertheless followed his usual

(Continued on Next Page)

practice of informing the patient of the nature of the procedure and of its significant collateral risks and hazards. However, the physicians of Ohio have long maintained that they are put at a disadvantage in this "swearing match," particularly when one recalls the statement of two law school professors who wrote recently in one of the leading law review articles on "informed consent" that: "A trial lawyer's healthy cynicism tells him that a claimant's testimony is sometimes susceptible to modification based upon hindsight." In an effort to bring the scales of justice into more even balance the Ohio State Medical Association has sponsored legislation in recent years in the General Assembly which would not only encourage the patient and physician to reduce these important discussion to writing but would then permit the physician to introduce into evidence and rely upon such writing to adequately defend himself against claims of "informed consent."

Another situation similar to the "informed consent" doctrine is the rule of law which imposes liability upon the physician for alleged oral guarantees of a good result or of a specific cure. While OSMA recognizes the right of a patient to collect damages for breach of a promise of a guarantee of a specific or of a good result but, again given the nature of people's recollections under the circumstances of a bad medical result, it believes that such promises, if they are to be the basis of civil liability, should be reduced to writing. For this reason the Ohio State Medical Association has sponsored legislation to amend the stature of frauds accordingly.

I have attached copies of both of these bills to my written testimony and I commend these legislative proposals to your attention (Bills are ommitted from this printing.)

A word about contingent fees. There is nothing unique about medical malpractice claims so far as the contingent fee situation is concerned, but physicians generally share the concerns expressed by other members of the public that perhaps the contingent fee arrangement for compensating plaintiff's lawyers under our present tort system has been abused and should be brought under regulation. OSMA recognizes that the Ohio Supreme Court has extensive, if not exclusive, jurisdiction in the matter of the licensing and supervision of the conduct of lawyers, including the use or abuse of contingent fees. We would point out for the record that the New Jersey Supreme Court recently adopted a rule regulating lawyers' contingent fees that contained a sliding scale and we believe that such a system of regulation would tend to correct abuses and has much to commend it, although we realize that its eventual adoption would, in all probability, be outside the scope of authority exercised by the Department of Insurance.

To summarize, it is the judgment of the Ohio State Medical Association that the traditional tort system for resolving medical malpractice disputes should not be abandoned at this time. We recognize, however, that the present system is not only expensive in terms of the cost of professional liability insurance needed to cover the risks inherent in such a system but also that certain abuses in the system should be corrected. This is not to say that OSMA has a fixed position as to any proposed alternative to the present tort system and we welcome the opportunity to participate in any discussion which this hearing may provoke in terms of alternatives.

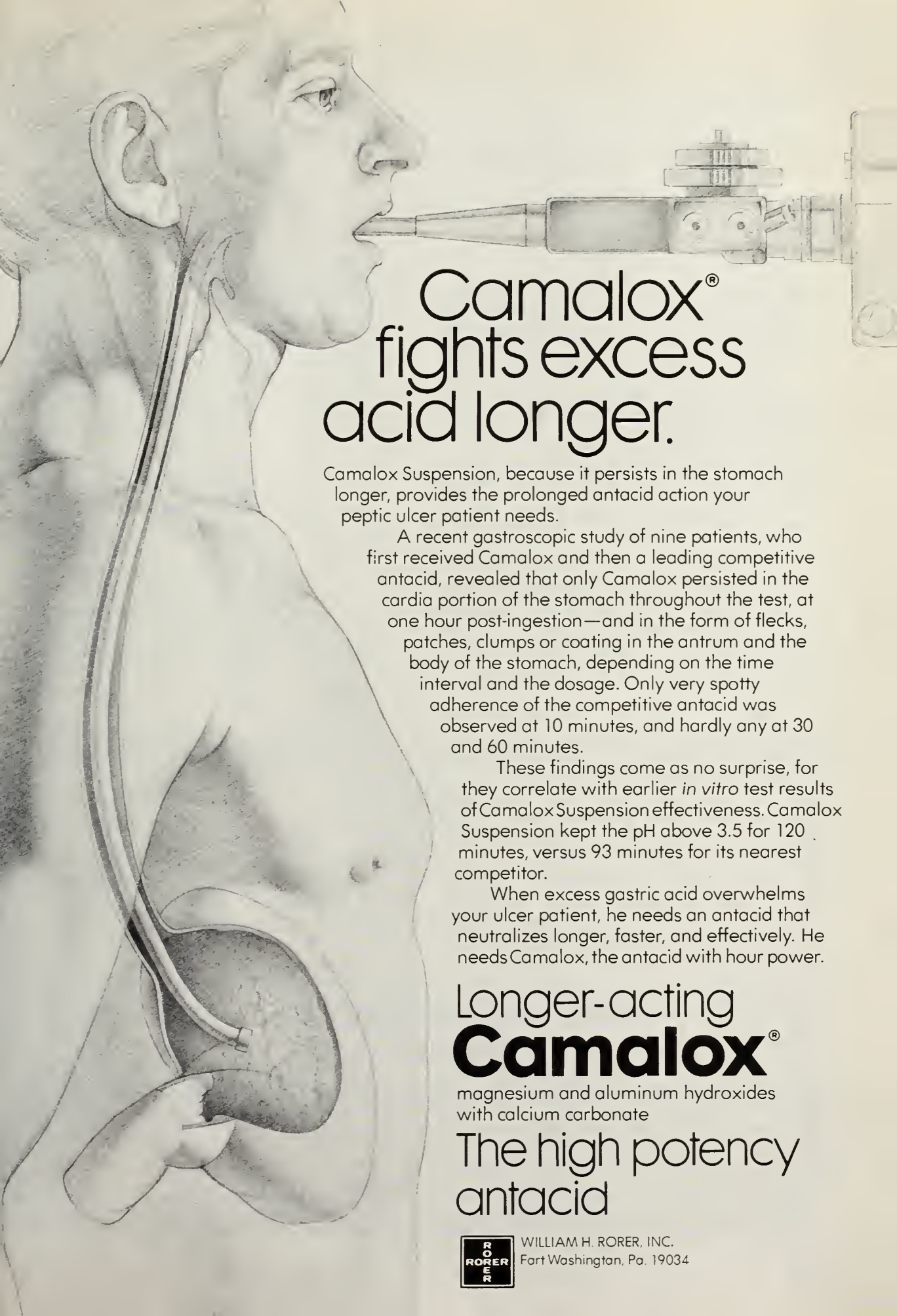
In this regard we are aware, for example, that one of the recommendations of the Secretary's Commission on Medical Malpractice was to urge experimentation with arbitration as an alternative to litigation as the means for resolving medical malpractice disputes. It is the position of OSMA that arbitration proposals deserve further study and merit careful consideration. We believe that its most promising use may lie in disposing of minor claims (such as those involving less than $5,000.00 or $10,000.00) and in disposing of claims arising in certain types of health care delivery systems (such as health maintenance organizations). OSMA does not view arbitration, however, at this time as being a complete and exclusive alternative to the present tort system and we note in conclusion, that certain variations of the arbitration theme, such as the so-called pretrial arbitration "screening panels" have met with little success in several of the Ohio metropolitan areas in which they have been introduced, notably Columbus and Dayton.

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Clinical Progress in Gastroenterology — Akron City Hospital, Akron; Nov. 20; fee is $5; contact: Institute of Medical Education, Akron City Hospital, Market and Arch Sts., Akron, 44309.

Gastroenterology: Clinical Problems — Nov. 20-21; fee is $80; contact: Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland, 44106.

Gout and Other Metabolic Arthritides — University of Cincinnati Medical Center, Cincinnati; Nov. 21-22; contact: University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, 234 Goodman St., Cincinnati, 45229.

Gastroenterology for the Primary Physician— Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; Nov. 30-Dec. 1; fee is $50; contact: The Ohio State University College of Medicine, Center for Continuing Medical Education, 320 W. 10th St., Columbus, 43210.

December

Fluid and Electrolyte With Special Emphasis on Urologic Problems — University of Cincinnati Medical Center, Cincinnati; Dec. 4; fee is $35; contact University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, 234 Goodman St., Cincinnati, 45229.

Urology X-Ray — Netherland Hilton Hotel, 5th St., Cincinnati; Dec. 5-7; contact: University of Cincinnati College of Medicine, Office of CONMED, Dean's Office, 234 Goodman St., Cincinnati, 45229.

Cardiology — Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus; Dec. 6; fee is $40; contact: The Ohio State University College of Medicine, Center for Continuing Medical Education, 320 W. 10th St., Columbus, 43210.

A Day of Cardiology — Akron City Hospital, Akron; Dec. 18; fee is $5; contact: Institute of Medical Education, Akron City Hospital, Market and Arch Sts., Akron, 44309.

Third Annual Review Courses in Nephrology, Veterans Administration Hospital, 4100 W. Third St., Dayton 45428; 1:00 to 2:00 p.m.; contact H. Mehbod, M.D., at the center. Dec. 2, **Hematological Aspects of Kidney Disease,** J. C. Chang, M.D.; Dec. 6, **The Nephrotic Syndrome,** Dr. Mehbod; Dec. 9, **Urinary Tract Infections and Interstitial Nephritides,** Dr. Mehbod; Dec. 13, **Kidney Stones and Obstructive Nephropathies,** Dr. Mehbod; Dec. 20, **Kidney in Heart Disease and Heart in Renal Failure,** E. Tabesh, M.D.; Dec. 23, **Cystic Diseases of the Kidneys,** Dr. Mehbod; Dec. 30, **Renal Tubular Disorders,** Dr. Mehbod.

January 1975

Current Review of Upper GI Surgery—Akron City Hospital, 525 E. Market St., Akron 44309; Cosponsored by American College of Surgeons; Jan. 9-10.

Third Annual Review Courses in Nephrology, Veterans Administration Hospital, 4100 W. Third St., Dayton 45428; 1:00 to 2:00 p.m.; contact H. Mehbod, M.D., at the center. Jan. 6, **Kidney in Gout, Diabetes Mellitus, Myeloma, Amyloidosis and Collagen Disorders,** Dr. Mehbod; Jan 10, **Kidney in Liver Diseases,** G. Gourgoutis, M.D.; Jan 13, **Nephrosclerosis,** Dr. Mehbod.

A Day of Pulmonary Function — Akron City Hospital, 525 E. Market St., Akron 44309; Jan. 15.

Controversies in Surgery — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Jan. 15-16.

Family Medical Review — Sponsored by Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; Place of meeting, Imperial House North, Columbus; Jan. 11-12, and Jan. 25-26.

Gastroenterology — Sponsored by OSU College of Medicine Center for Continuing Medical Education; 320 W. Tenth St., Columbus 43210; Meeting at Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; Jan. 29.

Medical Progress for the Family Physician — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Cosponsor, American Academy of Family Practice; Jan. 29-30.

February

Renal Disease Symposium — University of Cincinnati College of Medicine, CONMED, 234 Goodman St., Cincinnati 45229; Feb. 3-7.

Infectious Diseases — OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; Meeting at Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; Feb. 5.

Sports Medicine — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Feb. 5-6.

Pressure in Anesthesiology — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Feb. 7-9.

Pediatric Workshop — Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; cosponsored by Indiana Academy of Family Physicians; at Hueston Woods Lodge, College Corner, Ohio; Feb. 8-10.

Ear, Nose, Throat Disorders — Sponsored by OSU College of Medicine Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; Meeting at Stouffer's University Inn., 3025 Olentangy River Road, Columbus; Feb. 19.

Annual Infectious Disease Conference — University of Cincinnati College of Medicine, CONMED, 234 Goodman St., Cincinnati 45229; Feb. 20.

Orthopaedic Problems — OSU College of Medicine Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; Meeting at the Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; Feb. 26.

Blood Bank Management — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Feb. 26-27.

March

Core Curriculum: Pediatric Echocardiography — Sponsored by the American College of Cardiology, Cincinnati, March 17-20, 1975. For details, contact: American College of Cardiology, Department of Continuing Education Programs, 9650 Rockville Pike, Bethesda, Md. 20014.

May

Microneurosurgery Symposium, Cincinnati Convention Center, May 29-31, 1975. Directors: Stewart B. Dunsker, M.D., and John M. Tew, M.D. Lectures, practical demonstrations and discussions will be provided by an international faculty. Special courses for nurses and surgical assistants also will be conducted. Sponsored by the Departments of Neurosurgery, The Christ and Good Samaritan Hospital, Frank H. Mayfield,, M.D., Director. For details, write: Ms. S. Stuckey, Coordinator, Microneurosurgery Symposium, 506 Oak St., Cincinnati 45219.

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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during August. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CLARK (Springfield)
Kirat Ahmed
James L. Cromwell
Syed A. Haleem
William O. Smith, Jr.

CUYAHOGA
Edde Cinti
Chagrin Falls

FRANKLIN (Columbus, except as noted)
Romono Barney
Reynoldsburg
Gan Hok Bing
Thomas G. Hardy, Jr.
Gerard S. Kakos
Jack A. Morgenstern
Thomas A. Nims
Stephen F. Pariser
Robert A. Pugliese
Worthington
Joseph Schlonsky

HAMILTON (Cincinnati)
Robert D. Bohl
Hector M. Cabot
James T. Cook, III
Karl A. Guter
David A. Mrazek
David W. Semian

KNOX
Edward D. Blackburn
Fredericktown

LICKING
Philip J. Coverdale, Jr.
Newark
Young Sik Moon
Newark

LUCAS (Toledo)
Aruna C. Matani
Michael J. Rench
F. C. Swenson

MARION (Marion)
Victor H. Bazzoli
Angelito V. Belardo
Orpha T. E. Belardo
Tsongshen Chen
Robert Kirshen
Rimas A. Liauba
Robert T. McKinlay
Joseph C. Mirabile
Kazi Mobin-Uddin
Charles L. Rich
William H. Schory
Abdul K. Yousef

MONTGOMERY
Oscar B. Cataldi
Dayton
Y. Narasimha Reddy
Dayton

PORTAGE
Myung Woo Rhee
Ravenna
William Chiu-Lap Tsang
Atwater

SUMMIT (Akron, except as noted)
Mirza N. Ahmad
Kian Ho Bhe
Keith P. Blankenbuehler
A. Lawrence Cervino
Benito Mena
Cuyahoga Falls
Yee Tun Wu
Barberton

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during September. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CUYAHOGA
Felix J. Martin
Cleveland

GALLIA
Reid C. Brubaker
Gallipolis

LORAIN
Florencio E. Yuzon
Amherst

MAHONING (Youngstown, except as noted)
Thomas F. Barrett
Danny Chung
Hubbard
Emil R. Constantinidi
Alfred Reed Hoffmaster

MARION
Pavanender Gupta
Marion
Jaime M. Pua
Marion

RICHLAND
Larry R. Feichtner
Mansfield
Robert L. Mohl
Mansfield

STARK (Canton)
Surendranath Dash
Domingo Gonzalez
Soo Sup Lah
Teresita C. Marcelo
Marino G. Ong
S. Raja Ramalingam
James L. Reinglass
Muthusamy Sundararajan
Ramamohan R. Vellanki

SUMMIT (Akron, except as noted)
Manohar N. Apte
Cuyahoga Falls
Rogel R. Belmonte
Mario R. Brezler
Jose Dy
Dennis A. Glazer
Hae Wohn Johng
Cuyahoga Falls
Sam E. Rajiah
Cuyahoga Falls
Mohan Ray
James So Tan

TRUMBULL
Arlington G. Kuklinca
Warren

The Fifth Annual Aspen Radiology Conference will be held March 3-7, 1975, at the Aspen Institute for Humanistic Studies, Aspen, Colorado. Further information may be obtained from Maurice O'Connor, M.D. Conference Director, Division of Radiology, Denver General Hospital, Denver, Colorado 80204.

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Pulmonary Angiography as an Aid to Resectability in Bronchogenic Carcinoma

F. L. Mendez, Jr., M.D.
Owen L. Brown, M.D.
R. C. Rooney, M.D.

IN SPITE OF ALL EFFORTS at preoperative evaluation, bronchogenic tumors occasionally are not resectable. To obtain additional information concerning this situation, pulmonary angiography was carried out in a group of patients with bronchogenic carcinoma. Although tumor resectability may not be reflected in an increase in patient survival, surgical removal of bronchogenic tumors remains as the only possible chance for the individual patient. Radiotherapy has been of limited value and is considered a poor second choice. Conventional radiography of the thorax gives inadequate information when applied to the question of tumor resectability. The technical problems of such a resection can only be guessed at. Where resectability can be definitely established preoperatively, it may be possible to avoid the "open and close" procedure.

Anatomically, the dissection of either lung from an intrapericardial approach is a much simplified technic. What remains preoperatively is to evaluate the possibility of such a resection. Pulmonary angiography, as done in this department, gives valuable knowledge as to the length, patency, and size of the pulmonary arteries and veins. Where tumors prevent the dissection and ligation of these vessels, the pulmonary angiogram warns of technical failure. In the right thorax, the division and ligation of the azygos vein greatly aids the approach to the right pulmonary artery. When the superior vena cava can be rotated vertically and anteriorly, the right pulmonary artery can be exposed to its very origin. In the left thorax, careful division of the ductus arteriosus allows exposure of the left pulmonary artery to its origin. The pulmonary veins can be readily controlled by auricular crossclamping or, on the right, by additional dissection behind the right auricle.

In such situations, the additional information concerning the size, length, and the "availability" of these vessels greatly aids in making the surgical decision. When pulmonary angiography indicates the major pulmonary artery is involved by tumor at its origin, resection is not feasible and surgical intervention is correctly withheld. Should the pulmonary veins be involved or obstructed, angiography indicates the anatomical problems which may prevent successful resection. Dissection of the mediastinal and carinal lymph nodes is always carried out. We *do not* consider such nodal involvement to be a contraindication or a deterrent to a successful tumor resection. Although resection of the main bronchus does not imply a curative procedure, endoscopy will give a ready evaluation of the bronchial involvement.

All the candidates for pulmonary resection are studied thoroughly. The diagnosis is authenticated by tissue pathology. In some cases, an ac-

From the Department of Radiology, The Christ Hospital, Cincinnati, Ohio.
Dr. Mendez, Cincinnati, is Attending Thoracic Surgeon, Christ and Bethesda Hospitals, Cincinnati; and Consultant in Thoracic Surgery, St. Luke Hospital, Ft. Thomas, Ky., and St. Elizabeth Hospital, Covington, Ky.
Dr. Brown, Cincinnati, is Attending Radiologist, Christ and Cincinnati General Hospitals; and Assistant Clinical Professor of Radiology, University of Cincinnati College of Medicine.
Dr. Rooney, Cincinnati, is Chief Surgical Resident, Cincinnati General Hospital, University Medical Center.

curate pathological diagnosis may not be possible and a thoracotomy must be carried out for the diagnosis as well as therapy. Every effort is made before surgical therapy is considered to exclude extrapulmonary metastases. At this point, pulmonary angiography is carried out and the decision is made concerning the possibility of a successful resection. Should the angiogram reveal changes which preclude a successful resection of the tumor, thoracotomy is avoided. The patient is then considered for irradiation or chemotherapy, or *all* therapy is withheld. Pulmonary angiography gives the surgical group valuable information. Such information can only be guessed at by any other indirect method presently available (Figs. 1 and 2).

Case Reports

Case 1. A 72-year-old white woman was complaining of hemoptysis and cough for a period of six months. Previous bronchoscopy and bronchogram failed to substantiate the diagnosis of a pulmonary neoplasm. Subsequent radiologic observation revealed an increase in the size of the pulmonary lesion. The patient entered the hospital for exploratory thoracotomy and definitive pulmonary surgery. The bronchogram indicated involvement of the right, middle, and lower-lobe bronchi. A pulmonary angiogram revealed obstruction of the right middle-lobe and the right lower-lobe arteries (Fig. 3). The inferior pulmonary vein was also occluded (Fig. 4). When the data was analyzed, it was apparent that a right pneumonectomy would be necessary. At the time of the surgical effort, a resection at the level of the bronchus intermedius was not possible. A right pneumonectomy was successfully carried out at the *intrapericardial level.*

The postoperative course was uneventful, although assisted ventilation was carried on for five days. The patient remains alive and free of tumor at the present time.

This patient presented the problem of a possible surgical failure because of inability to resect the intracardiac extension of the tumor. Pulmonary angiocardiography revealed that the resection could be accomplished at the intrapericardial level. Such studies also indicated that a pneumonectomy would be required, and thus the postoperative course was programmed for this approach.

Case 2. A 66-year-old white man was seen with the diagnosis of bronchogenic carcinoma arising in the left lower lobe bronchus. Bronchoscopy and bronchogram revealed the lesion just beyond the left upper lobe orifice involving the lingula (Fig. 5). Pulmonary angiography was carried out to evaluate the length and involvement of the left main pulmonary artery (Fig. 6). On the basis of angiography, the lesion was considered resectable. A left pneumonectomy was carried out at the intrapericardial level. Closure of the left pulmonary artery was effected at the bifurcation of the main pulmonary artery. This patient died six months later from hepatic and cerebral metasteses.

In this situation, the risk of a surgical failure definitely had to be considered. The pulmonary angiogram, however, indicated that the resection would be possible, but only at the level of the



Fig. 1. Normal pulmonary arteriogram, arterial phase.



Fig. 2. Normal pulmonary arteriogram, venous phase.



FIG. 3. Pulmonary arteriogram reveals obstruction of right middle and lower lobe arteries (case 1).



FIG. 4. Venous phase of pulmonary arteriogram shows nonvisualization of right inferior pulmonary vein (case 1).

bifurcation of the main pulmonary artery. Technically, the operative intervention was successful, and mere exploration was avoided.

Case 3. A 51-year-old white man was seen with bronchogenic carcinoma of the right lung. Bronchoscopy revealed no evident endobronchial lesion. Cytology was positive for tumor cells. Radiologically, the right lung revealed considerable involvement in spite of the absence of intrabronchial tumor (Fig. 7). Pulmonary angiography was carried out and revealed good filling of the right pulmonary artery (Fig. 8) but poor filling of the right pulmonary veins (Fig. 9). Resection of the tumor was considered questionable and further surgical efforts were abandoned.

In this instance, the various radiologic technics, including the pulmonary angiogram, indicated that surgical intervention would not succeed.



FIG. 5. Bronchogram reveals occlusion of lower lobe bronchus at its origin and filling of only a short stump of lingular bronchus (case 2).



FIG. 6. Occlusion of descending branch of left pulmonary artery (case 2).

Surgery was not offered as a feasible solution to the problem. Radiotherapy was refused, and the patient was treated symptomatically. At the patient's death, the postmortem examination revealed massive mediastinal involvement and at that time, the tumor was not technically respectable.

Case 4. A 40-year-old white man, who was asymptomatic, was seen in consultation. Routine radiologic examination of the chest revealed a left upper lobe lesion (Fig. 10). Bronchoscopy, laminography, and a bronchogram all suggested a malignant lesion. The pulmonary angiogram indicated a sharp cut-off at the level of the bifurcation of the main pulmonary artery (Fig. 11). Because of the patient's age and physical appearance, exploratory thoracotomy was undertaken. Intrapericardial dissection with division of the ductus arteriosus was necessary in order to effect control of the left pulmonary artery. Pneumonectomy was possible but only within the pericardium. The pathologic report revealed this to be an inflammatory lesion with complete occlusion of the left pulmonary artery. The postoperative recovery was uneventful and the patient remains well at this time.

This case reveals the advantage of pulmonary angiography in the benign pulmonary lesion. Angiography of the pulmonary vessels indicated that the resection would be within the pericardium or such resection would not be possible. Such additional information allows the surgical team to make a direct approach and decreases the time wasted in a futile hilar dissection.



Fig. 8. Pulmonary angiogram reveals no involvement of right pulmonary artery or its branches (case 3).

Case 5. A 65-year-old white man was complaining of dyspnea, chest pain, weight loss, and cough. Bronchoscopy established the lesion to be an undifferentiated carcinoma of the right bronchus (Fig. 12). Pulmonary angiography revealed the pulmonary artery to be readily dissectable (Fig. 13), but the inferior pulmonary vein on the



Fig. 7. Plain chest roentgenogram shows discrete mass lesion below right hilum (case 3).



Fig. 9. Pulmonary angiogram, venous phase. Note failure of filling of right inferior pulmonary vein (case 3).



FIG. 10. Plain chest roentgenogram shows left hilar mass with linear infiltrate extending into upper lobe (case 4).

right was occluded (Fig. 14). A resection of the lung was considered technically feasible, but was not carried out because of cerebral metastasis.

The pulmonary angiogram revealed that this patient's lung could be resected but that the inferior pulmonary vein would require resection at



FIG. 12. Plain chest roentgenogram shows diffuse density obscuring right heart border with some shift of midline structures toward right side (case 5).



FIG. 11. Pulmonary angiogram reveals abrupt occlusion of left main pulmonary artery at its origin (case 4).

the auricular level. Pulmonary resection was withheld because of metastasis beyond surgical control.

Conclusion

Although well-known for many years, angiographic study of the pulmonary vascular system has found little practical application. This study was undertaken to evaluate the use of pulmonary angiography as an adjunct in the therapy of bronchogenic carcinoma. Too frequently, thoracotomy for such lesions results in a surgical exercise but is of no value to the patient. Failure to remove the offending tumor leaves the patient

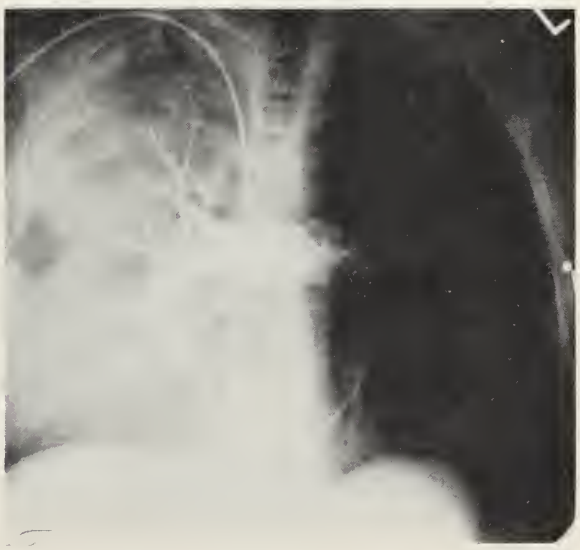


FIG. 13. Pulmonary angiogram with selective injection shows no arterial involvement (case 5).



Fig. 14. Venous phase of pulmonary angiogram shows occlusion of right inferior pulmonary vein (case 5).

without hope of a cure, but only after considerable risk, pain, and expense. If additional information can be used to prevent such unsatisfactory procedures, we feel pulmonary angiography would be of considerable value.

The technic of pulmonary angiography has been proven to be safe and effective. We believe the application of this technic to the preoperative assessment of bronchial tumors, where indicated, is long overdue.

In these selected case studies, we have attempted to illustrate the value of such pulmonary vessel visualization. With such information at hand, the physician is better prepared to make the correct decision concerning the application of the surgical technics. If it is radiologically evident that removal of the lesion is not possible, the thoracotomy is avoided and the patient is spared the experience. Again, the surgical approach may be redesigned or tailored in the light of such evidence. We have often found that a pneumonectomy could be successful, whereas any less tissue resection was not technically feasible. Thus prepared, the patient risk can be better evaluated and the procedure can be physiologically carried out. Intrapericardial pulmonary resection, when indicated, is a much simpler technic. Where angiocardiography of the pulmonary vessels reveals involvement at the pulmonary hilum, resection can be carried out only at a more proximal level. Unless this fact is appreciated, many such patients will be considered inoperable and, therefore, be abandoned. Pulmonary angiography, then, may prevent exploratory thoracotomy and its connotation of defeat. When the surgeon is prepared to resect the lesion within the pericardium, only a few lesions remain beyond such surgical expertise.

It is at this crucial point that pulmonary angiography has its application. Information gleaned from such a study will give the operating physician a firm foundation upon which to base his judgment for or against surgical intervention. Such a decision need not be a voyage on an uncharted sea.

It must be evident to the informed reader that extending the limits of tumor resection is not the same as increasing the five-year survival rates. Thus, many such resections are doomed by the nature of the disease under treatment. However, until another modality of therapy which offers a better chance is available, the thoracic surgeon must continue to do all that is possible to aid patients with bronchogenic carcinoma. Pulmonary angiography will give the thoracic surgeon a little more information upon which to make the decision. Try it, you'll like it!

Cecal Mass Due to Intussuscepted Appendix

A Plea for Conservative Therapy

Ivan L. Shapiro, M.D.
H. Treat Cafferata, M.D.

THE RARITY OF APPENDICEAL intussusception leads to its infrequent consideration in the differential diagnosis of cecal masses. During a laparotomy for exploration of a cecal mass, the correct diagnosis of intussuscepted appendix was made, and the patient was spared a needless right hemicolectomy. The purpose of this presentation is to review the recent information available in relation to this case, with a plea for avoiding unnecessary surgery.

Case Report

A 45-year-old white woman presented with abdominal pain and fever. One week prior to admission, she noted the sudden onset of diffuse lower-abdominal pain and bloating. She denied nausea, vomiting, diarrhea, constipation, or urinary and respiratory complaints. At home, her temperature varied between 37.8 C and 40.0 C (100 F and 104 F). Six years ago, a similar episode of abdominal pain resulted in hospitalization and a uterine dilatation and curettage was performed. The diagnosis of endometriosis was made at that time.

Results of physical examination and the laboratory data were unremarkable except for a temperature of 38.6 C (101.4 F) and a white blood count (WBC) of 19,500 per cu mm with 80 percent neutrophils.

Her temperature rose initially to 40.0 C (104 F), but declined over the next five days and on the sixth day, she was afebrile. She remained asymptomatic otherwise. Excretory urogram was normal. Barium enema showed a 2-cm, slightly lobulated, filling defect in the cecum and spasm in the sigmoid colon (Fig. 1). Sigmoidoscopy was normal to 25 cm. Repeat barium enema again demonstrated the cecal mass, but the sigmoid spasm was no longer present.

At laparotomy through the midline, the pelvic organs were adherent to each other without evidence of recent inflammation or neoplasm. A round, umbilicated mass was felt in the inferior-medial wall of the cecum. The appendix was not visible at this time. There was no evidence of tumor involving the cecal serosa, colon or small bowel mesentery, lymph nodes, or liver. Since the preoperative evaluation revealed no strong evidence of malignancy, the cecal mass was presumed to be the result of a chronically inflamed, retrocecal appendix. The cecum and right colon were mobilized and the appendiceal tip was identified in a retrocecal position. The remainder of the appendix was palpated and its location was determined to be both intramural and intracecal. Traction on the appendix with countertraction on the cecum failed to facilitate delivery of the appendix. Likewise, evagination of the mass, by pressure from the lateral cecal wall, was unsuccessful. A 4-cm cecotomy through the anterior taenia was done, and the lesion was identified in its intracecal position (Fig. 2). After reduction was



FIG. 1. Barium enema shows a 2-cm filling defect in the cecum.

This paper was prepared by the authors at Noble Army Hospital, Fort McClellan, Ala.
Reprint requests to Division of Thoracic Surgery, The Ohio State University Hospitals, 410 W. Tenth Ave., Columbus, Ohio 43210 (Dr. Shapiro).
Submitted February 25, 1974

easily accomplished with direct pressure on the mass from within, the cecotomy was closed in two layers with catgut and silk. The appendix (Fig. 3) was removed by ligation of its blood supply, amputation and inversion by means of a cecal purse-string suture. Recovery was uneventful. Microscopic examination revealed ulcerated appendiceal mucosa, chronic inflammation, and clearly definable endometrial glands and stroma (Fig. 4).

Discussion

In this cancer-conscious age, the discovery of a cecal mass is both a concern and a challenge to the surgeon. In view of the marked variability in instances associated with appendiceal intussusception, it may be detected first by barium enema, as in our case, or by palpation of the cecum at laparotomy. Malignancy is usually the first consideration for cecal masses. However, the correct diagnosis of appendiceal intussusception will prevent an unnecessarily extensive surgical procedure.

Since McKidd's original description in 1859,[1] many cases have appeared sporadically in the English Literature. In spite of incomplete bibliographies, approximately 125 cases have been published.[2] While the literature is replete with descriptions of nonmalignant cecal masses, several publications have emphasized the charade of malignancy, and many of the cases reported have been treated by right hemicolectomy.[2-4]

The etiology of the intracecal appendix is both interesting and variable. In addition to appendiceal intussusception for no apparent reasons, the surgeon often creates a cecal wall mass by inversion of the appendix, an unnecessary practice. Moreover, Alfthan and Vara reported a large series of patients with prophylactically inverted appendices.[5] We cannot agree with this unnecessary operation which may cause confusion in interpreting the barium radiograph. In addition to a highly mobile, relatively nonfixed appendix with scant mesentery, as an etiology, conditions predisposing to "lead points" may enhance intussusception. These are: lymphoid hyperplasia, fecaliths, prolapse of appendiceal mucosa, polyps, worms, mucoceles, endometriosis, and argentaffin tumor.[1, 6-14]

The foregoing may seem to negate the difficulty in establishing an accurate preoperative diagnosis, but such is not the case. Certainly the justification for performing a laparotomy for cecal mass exploration is obvious. Although inflammatory and malignant changes often appear confusingly similar on gross inspection and may coexist in the same lesion, the following preoperative factors should cause strong consideration for the diagnosis of "probably benign mass:" age below 40 years, absence of anemia, no melena or hematochezia. The following operative findings suggest nonmalignancy: mobile cecum, normal serosa, absence of enlarged regional nodes, hepatic



Fig. 2. Operative photograph showing intussuscepted appendix through anterior cecotomy. Appendiceal lumen is visible.

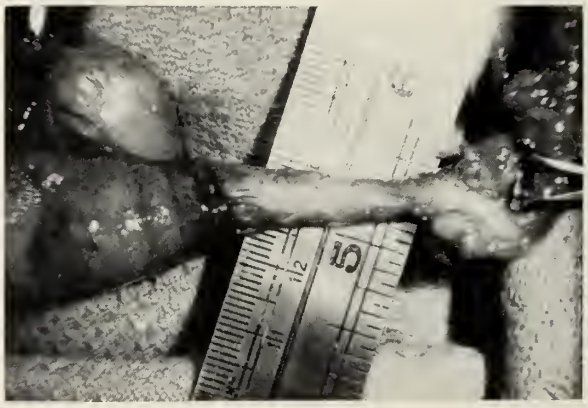


Fig. 3. Operative photograph showing appendix reduced from its intussuscepted position.

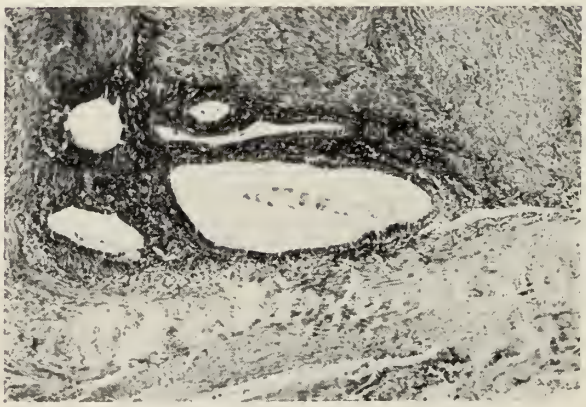


Fig. 4. Photomicrograph through appendiceal wall shows chronic inflammation and endometrial glands.

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Dr. Cafferata is in the practice of general surgery in Reno, Nevada.

nodules, and obvious metastases. Specifically, appendiceal intussusception should be suspected when an inverted appendix, absent appendix without previous appendectomy, or endometriosis are noted.

With these factors in mind, the surgeon should weigh the possibility of benign versus malignant disease and should consider conservative rather than radical surgery. If carcinoma is the probable diagnosis after a thorough abdominal examination, a "no-touch," standard, right hemicolectomy should be performed. If the probable diagnosis is inverted, chronically inflamed, or endometriotic appendix, the surgeon may be able to deliver the appendix in the usual fashion, or the aid of a cecotomy may be required, as in our case. Further, partial cecectomy may be necessary in difficult cases.[12, 18]

Summary

A case is presented in which preoperative evaluation suggested nonmalignancy of a cecal mass. At laparotomy, intussusception of the appendix was diagnosed and pathologic section demonstrated that previous endometriosis involved the appendix. Because of the presumptive preoperative diagnosis and intraoperative findings suggesting nonmalignancy, it was felt that cecotomy was justified in order to facilitate delivery of the appendix and to avoid an unnecessary right hemicolectomy.

Acknowledgment: Dr. A. Preston Russell prepared and interpreted the pathologic specimen.

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Professional Activities



Proceedings of The Council

Meeting of September 20-22, 1974

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Friday evening, Saturday and Sunday, September 20, 21 and 22, 1974, at the Ramada Inn, Cincinnati, Ohio.

Those present Friday evening were: All members of The Council (with the exception of Dr. Smithson); Mr. James E. Pohlman, Columbus, OSMA Legal Counsel; John H. Budd, M.D., Cleveland, AMA Board of Trustees; Mr. Guy D. Beaumont, Jr., Columbus, Field Representative, AMA Public Affairs Division; and Messrs. Page, Edgar, Campbell, Clinger, Rader, Houser, Holcomb, Mulgrew, Mrs. Wisse and Mrs. Dodson, of the OSMA Staff.

Those present Saturday were: All members of The Council; Mr. Pohlman; Dr. Budd, Mr. Beaumont, and all members of the OSMA Staff.

Those present Sunday were: All members of The Council; Dr. Budd; Mr. Beaumont, and all members of the OSMA Staff (with the exception of Messrs. Edgar and Holcomb).

The meeting was called to order by President Henry.

The Council received a letter from R. Gordon Moore, Executive Editor of *The Ohio State Medical Journal* and the President announced that it was Mr. Moore's final official Council meeting, and thanked him in behalf of the Council for his 27 years of loyal service to the Association.

Mr. Brent Mulgrew, Assistant to the Director of State Legislation, was present and was introduced to the Council.

The minutes of the July 27-28 meeting of the Council were approved.

Membership

Membership statistics were presented by Mrs. Wisse. The Council asked that lists of delinquent members be forwarded to members of Council.

Fiscal Matters

The minutes of the meeting of the Auditing and Appropriations Committee held September 21, were presented to the Council in Executive Session by Dr. Bates. The minutes were approved.

The Council approved a resolution on lease of space in the OSMA building to the Academy of Medicine of Columbus and Franklin County. The resolution reads as follows:

"Be it resolved, that the Lease Agreement and Memorandum of Lease between the Ohio State Medical Association and the Academy of Medicine of Columbus and Franklin County, in the form marked 'Exhibit A' and 'Exhibit B' respectively, and attached hereto and made a part hereof as fully as if rewritten herein, is hereby approved and the President of the Ohio State Medical Association is hereby authorized to execute and deliver said Lease Agreement and Memorandum of Lease in the name and on behalf of the Ohio State Medical Association."

American Medical Association

The Council approved the support of the following nominations from the American Medical Women's Association for AMA Councils and Committees: Roselyn F. Pariser, M.D.—Committee on Nursing, and Melanie S. Kennedy, M.D.—Committee on Transfusion and Transplantation.

Dr. Budd reported on actions of the AMA Board of Trustees.

The Council discussed the candidacy of Dr. William A. Sodeman, Toledo, for President-Elect of the American Medical Association. The Council referred the matter to Ohio's AMA Delegation for study and report back to the Council at the next meeting.

In answer to a letter from the American Medical Association, the Council considered the matter of financing the attendance of interns and residents from Ohio at American Medical Association House of Delegates meetings. It was Council's opinion that it was unable to act on this matter at this time, since there is no way provided to select interns and residents from among their peers to be granted this responsibility.

OSMA Annual Meeting

Mrs. Dodson presented the minutes of the Committee on Scientific Work, August 7, 1974 meeting. The minutes were approved, following amendments which changed the theme of the meeting to "Our Medicine is Good: Let's Make it Better," and recommended Dr. James H. Sammons, EVP Designate of the AMA, as first choice for General Session speaker.

The Council supported the Committee's objection to retrospective approval of the Annual Meeting for the AMA Physicians' Recognition Program under the procedures outlined by the Council on Medical Education of the AMA. It was felt that prior approval for state medical association meetings should be granted. The Council requested a resolution to the AMA House of Delegates in support of this policy.

MAI

The meeting of Council was adjourned for a meeting of the corporate membership of Medical Advances Institute.

Ohio Foundation for Medical Care

Minutes of the meeting of the Board of Trustees of the Ohio Foundation for Medical Care, held September 4, 1974, were presented by Mr. Campbell.

A plan to establish a joint statewide medical review and independent professional review program for Medicaid patients in skilled nursing facilities and intermediate care facilities and involving the Ohio Foundation for Medical Care and Medical Advances Institute was presented and discussed. The Council voted to accept the plan in principle and approved the involvement of Ohio State Medical Association and its affiliated corporations (MAI and OFMC) on a contract basis. A motion by Dr. Morgan, duly seconded, which called for the approval of the proposed plan for the Ohio Medical Review Program in Nursing Homes, was approved with one negative vote (Dr. Pichette).

Committee Reports

Medical Advisory Committee to Nationwide (Part B Carrier)

The minutes of the August 14 meeting of the Medical Advisory Committee to Nationwide (Part B Carrier) were presented by Mr. Houser. The report was accepted for information.

It was the recommendation of the Council that the matter of the post-payment utilization review of physician services, required by law since 1972, but not yet implemented by Nationwide Insurance, be referred to the Peer Review Systems Council of Medical Advances Institute for review and evaluation, with Dr. Metzger giving a presentation to the PRS Council. A report to the OSMA Council on the results of the review and evaluation was requested. It was requested that, in the meantime, Nationwide Insurance not communicate with local medical societies on the matter. In addition, it was requested that a proposed article in the Journal be delayed until the matter has been evaluated by the Council.

Committee on Health Manpower

The minutes of the September 12 meeting of the Committee on Health Manpower were presented by Mr. Clinger.

The report presented three concepts with regard to health manpower legislation:

1. Certification by the National Commission on Certification of Physicians' Assistants as a requirement prior to registration in Ohio.

2. Employment of no more than two physicians' assistants at any one time by a physician. The certificate of registration approved by the Ohio State Medical Board shall include the name and type of practice of the physician employing the physicians' assistant.

3. Type of practice and physical setting of the physicians assistant's work to be determined by and parallel to that of the employing physician.

The report was accepted.

Committee on Emergency and Disaster Medical Care

The minutes of the September 14 meeting of the Committee on Emergency and Disaster Medical Care were presented by Mr. Houser. The report was accepted as presented. The Council did not endorse a recommendation on emergency medical identification devices. The Council did approve a recommendation on the Governor's Task Force Report and asked that a letter be sent to Dr. Cashman communicating the action.

Commission on Medical Education

The minutes of the July 24 meeting of the Commission on Medical Education were presented by Mr. Edgar, who also presented the

Commission's Physicians Recognition Program, which had been mailed to the Council on August 22. The minutes and report were accepted as presented, with a target date of January 1, 1975, being designated for the implementation of the OSMA Physicians Recognition Program.

Committee on Membership and Planning

A review of the September 18 meeting of the Committee on Membership and Planning was presented by Dr. Wells as a progress report.

Council Fee Review Committee

The minutes of the September 20 meeting of the Council Fee Review Committee were presented by Mr. Campbell and were accepted.

Councilor Reports

An incident occurring in the Sixth Councilor District involving an act of censure by a group of members of that district was discussed by the Council.

The Council was convened in Executive Session for further discussion of the matter.

Subsequent to the discussion, the Council adopted unanimously the following motion: "That a letter be directed to the President of the Summit County Medical Society and the Sixth District Peer Review Organization, stating that the motion of censure is not an expression of the Ohio State Medical Association and that the President of this Association tender apologies on behalf of The Council to any members who were presumed to have been censured."

Mailing List Request

A request from a member in the Eleventh District for a mailing list of members was presented to the Council. A motion to give the Executive Director permission to send the list to him failed for want of a second. The president was authorized to communicate with the member with regard to the purpose of the mailing and to request the opportunity to review the nature of the communication prior to further consideration.

Ethics

The ethical relationship of a physician who is a member of a Health Maintenance Organization which conducts advertising of medical services was referred to the Committee on Judicial and Professional Relations for study and advice.

Federal Legislation

A report on federal legislation was presented by Mr. Edgar.

State Legislation

Mr. Rader reported briefly on developments in the field of state legislation.

Constitution and Bylaws

Proposed amendments to the Constitution and Bylaws of the Academy of Medicine of Cleveland were approved.

Malpractice Hearing

Mr. Campbell discussed an Ohio Department of Insurance hearing on Professional Liability Insurance, held September 18. He announced that Mr. Pohlman's testimony on behalf of the Ohio State Medical Association was well received and was reported in the media.

National Health Service Corporation

A request for approval of National Health Service Corps program in Putnam County involving the provision of an additional physician was approved contingent upon a proper certification of endorsement from the Putnam County Medical Society.

Battelle Study

A request from Battelle Memorial Institute for approval of a study to collect data on consumer product-related injuries was endorsed in principle.

Field Service Report

Mr. Holcomb was introduced and reported on his field service contacts in the interim since the last meeting of the Council.

Early and Periodic Screening, Diagnosis and Treatment Program

It was announced that President Henry is awaiting a communication on this subject from Welfare Director Charles W. Bates, as promised by Mr. Bates at a meeting between the Director and Dr. Henry August 29, 1974. The President was authorized by the Council to take a positive approach on this matter to continue negotiations for conducting the screening as a private physician's service on a fee for service basis and to report to the Council at the next meeting.

OMPAC

The Council reaffirmed OSMA support for the Ohio Medical Political Action Committee and for concurrent billing of OMPAC dues.

Health Education

Mr. Clinger reported on the cooperation of the Woman's Auxiliary to the OSMA in promoting K-12 comprehensive health education in Ohio's schools and the activities of the Ohio State Medical Association and its Auxiliary in promoting immunization in 1974.

Adjourned.

ATTEST: Hart F. Page
Executive Director

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Doctor, Your Generous Contribution to AMA-ERF Is A Solid Investment In Medicine Future

DOCTOR, your generous contribution to the 1974 Ohio campaign for the American Medical Association Education and Research Foundation can help eliminate the financial barrier to medical education for needy medical students, interns and residents.

Philip Hardymon, M.D., of Columbus, chairman of the Ohio AMA-ERF Committee which includes the 11 district councilors of OSMA, expressed confidence that the 1974 campaign would be highly successful. He cited the following statistics resulting from the 1973 campaign:

1. The four medical schools in Ohio received $49,105.84 as follows:

Case-Western Reserve University School of Medicine	$10,350.74
The Ohio State University College of Medicine	$15,250.59
The University of Cincinnati College of Medicine	$18,393.75
The Medical College of Ohio at Toledo	$ 5,110.76

2. A total of 157 loans (137 to medical students and 20 to interns and residents) were made in Ohio during 1973. These loans totalled $202,-500.00.

3. Since the inception in 1962 of the Student Loan Guarantee Fund, 2,025 loans totaling $2,259,850.00 have been made to Ohio medical students, interns and residents.

4. From 1962, AMA-ERF has guaranteed, and the participating banks have made, 51,797 loans totaling $59,481,275.00.

All this has been done by a private sector of the economy without government subsidy. This enviable record can be maintained with the help of Ohio physicians. Here are answers to some questions you may have concerning the Student Loan Guarantee Fund.

Did you know: That through the Student Loan Guarantee Fund, the struggling medical student may receive direct financial aid?

Did you know: That with increasing inflation it now costs more than $5,000 per year to attend medical school?

Did you know: That your contribution to the Student Loan Guarantee Fund will be held as a guarantee for repayment of loans? For each $1.00 you give, another $12.50 will be put to work in loans made by a commercial bank, and as these loans are repaid, the money is reactivated to help other students.



Philip Hardymon, M.D.

•

Did you know: That the accepted applicant becomes eligible for medical education loans of up to $1,500 a year? Additional applications may be approved each year so that a maximum of $10,000 can be borrowed over a seven year period.

Did you know: That the borrower pays only the established interest rate during his training, and has ten years after completion of training to repay the principal?

How do you contribute? Shortly after you receive this issue of the *Ohio State Medical Journal,* you will receive a letter from Dr. Hardymon and a special AMA-ERF return envelope. The inside of the envelope includes space for your choice of medical school to receive your contribution, choice of category for your contribution, and the amount of your contribution. The pre-addressed envelope containing your contribution goes directly to AMA-ERF headquarters in Chicago.

In summary, the AMA-ERF student loan program has been designed to alleviate the financial difficulties of medical students and to encourage career decisions in favor of medicine. The program utilizes the principal of a security fund functioning as a cosigning agency to make available through community banks relatively large sums of credit at a low rate of interest.

Realizing the importance of keeping medical education independent through private initiative and voluntary effort, Dr. Hardymon and members of the Ohio AMA-ERF Committee urge Ohio physicians to respond generously in this year's campaign.

YOU, Doctor, can become an important part of this program by contributing now. Where else can you buy so much for so little? Just think, a tax deductible contribution of $125 would guarantee a medical student's loan for one year.

If you have questions or need further information concerning the 1974-AMA-ERF campaign, don't hesitate to contact the OSMA office at 600 South High Street, Columbus, Ohio 43215, Area Code 614-228-6971.

Medical Society Executives Elect OSMA Staff Member

Douglas Houser, OSMA Administrative Assistant, was elected as a member of the American Association of Medical Society Executives (AAMSE) during its 1974 annual meeting.

As its name implies, membership in this organization is open to executive employees of national, regional, state, district or county medical societies or associations.

OSMA's Executive Director, Hart Page, is a member of the AAMSE Advisory Committee to the AMA Executive Vice-President as well as Chairman of the AAMSE Education Committee.

Other OSMA staff members who belong to the AAMSE are: Charles Edgar, Assistant Executive Director and Director of Public Relations; Jerry Campbell, Specialty Societies and Insurance Director; Dave Rader, Legislative Director; Robert Clinger, Health Education Director; and Katherine Wisse, Comptroller and Director of Membership Department.

Medical Assistant From Akron Is Elected National President

Laura L. Lockhart, a certified medical assistant-administrative (CMA-A) from Akron, is the new president-elect of American Association of Medical Assistants (AAMA). Members of AAMA's policy-making House of Delegates voted unanimously to elect Miss Lockhart during the 18th annual convention in Denver.

Miss Lockhart has worked as a medical assistant to ophthalmologist Devitt L. Gordon, M.D., for 20 years. During this time, she has been active in AAMA at national, state, and local levels. She served as national vice-president, speaker of the house, vice-speaker and trustee, as well as participating in various national committees.



Laura L. Lockhart

The new president-elect is a past president of the Ohio state chapter and Past District Councilor on the board of trustees, and has helped organize five new Ohio chapters. On the local level, Miss Lockhart has been president of the Summit, Ohio chapter of AAMA, treasurer, parliamentarian, and a member of the Board of Directors.

Based in Chicago, the AAMA is a national organization of more than 15,500 medical assistants working under the direct supervision of a licensed physician. One of the association's major objectives is to increase the education and professionalism of medical assistants.

The AMA has more dues-paying members now than it has ever had in its history. As of the end of September, there were 168,509 dues-paying AMA members. This total is 295 more than there were in AMA's highest previous membership year, 1970, when 168,214 dues-paying members were recorded. With three months left to report membership, figures are 6,976 ahead of the 1973 total.



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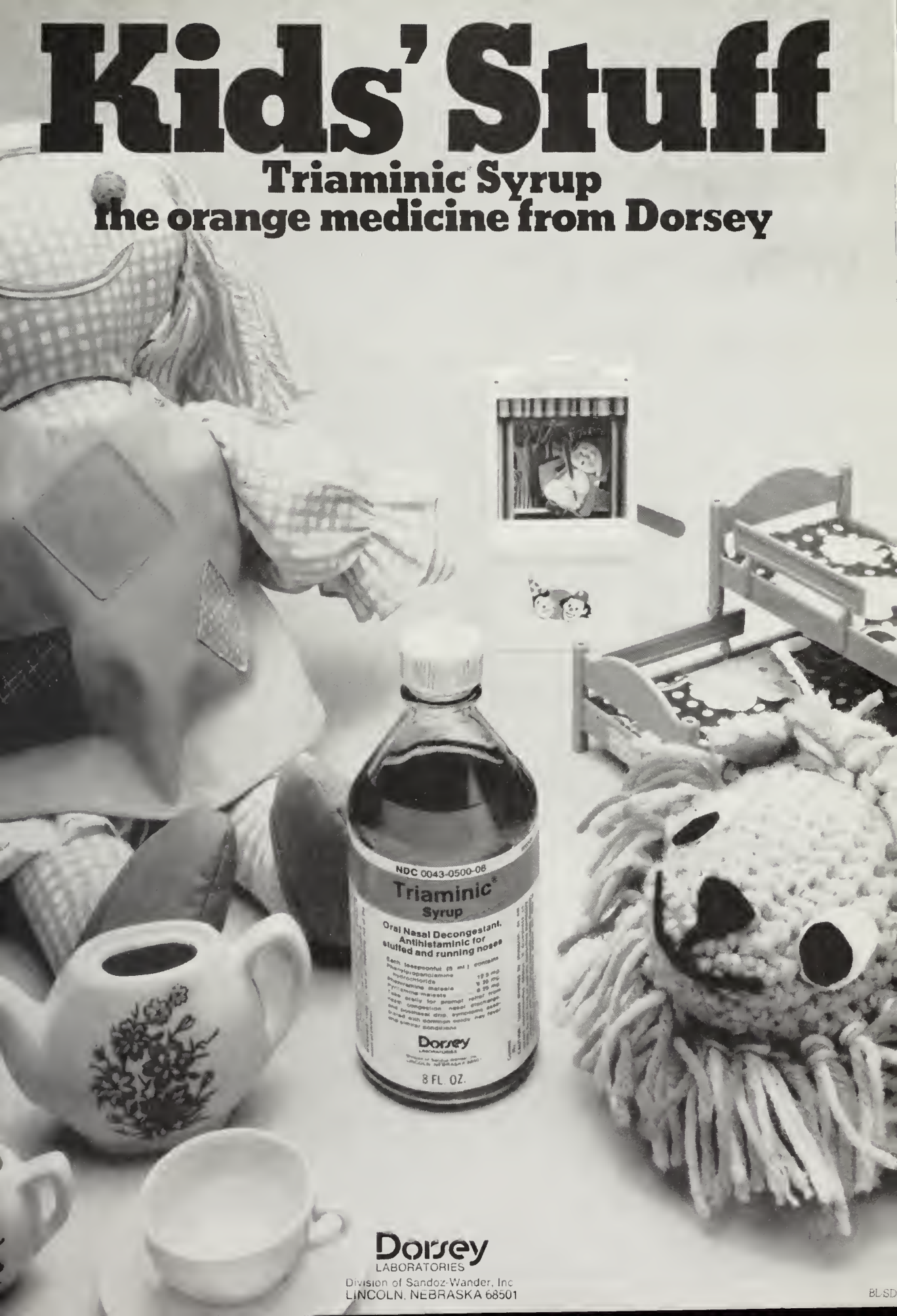
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X-ray studies[1] in 16 normal subjects showed just how promptly the active ingredient in Lomotil does its work.

Lomotil retarded gastrointestinal motility particularly during the first three hours after administration. It continued its moderating action on the bowel for at least three hours more.

Physicians prescribe Lomotil more often than any other drug when the urgency for the control of diarrhea is most distressing.

1. *Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.*

Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . 2.5 mg.
(Warning: May be habit-forming)
atropine sulfate . . . . . 0.025 mg.

Saves the Day



IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department, Box 5110,
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Sign of a cold* sufferer

Time for Ornade®

Each Spansule® capsule contains 8 mg. Teldrin® (brand of chlorpheniramine maleate); 50 mg. phenylpropanolamine hydrochloride; 2.5 mg. isopropamide, as the iodide.

Fast relief of upper respiratory congestion and hypersecretion* with convenient b.i.d. dosage.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Indications**
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Possibly effective: For relief of upper respiratory tract congestion and hypersecretion associated with vasomotor rhinitis and allergic rhinitis, and for prolonged relief.

Lacking in substantial evidence of effectiveness: For relief of nasal congestion and hypersecretion associated with the common cold and sinusitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

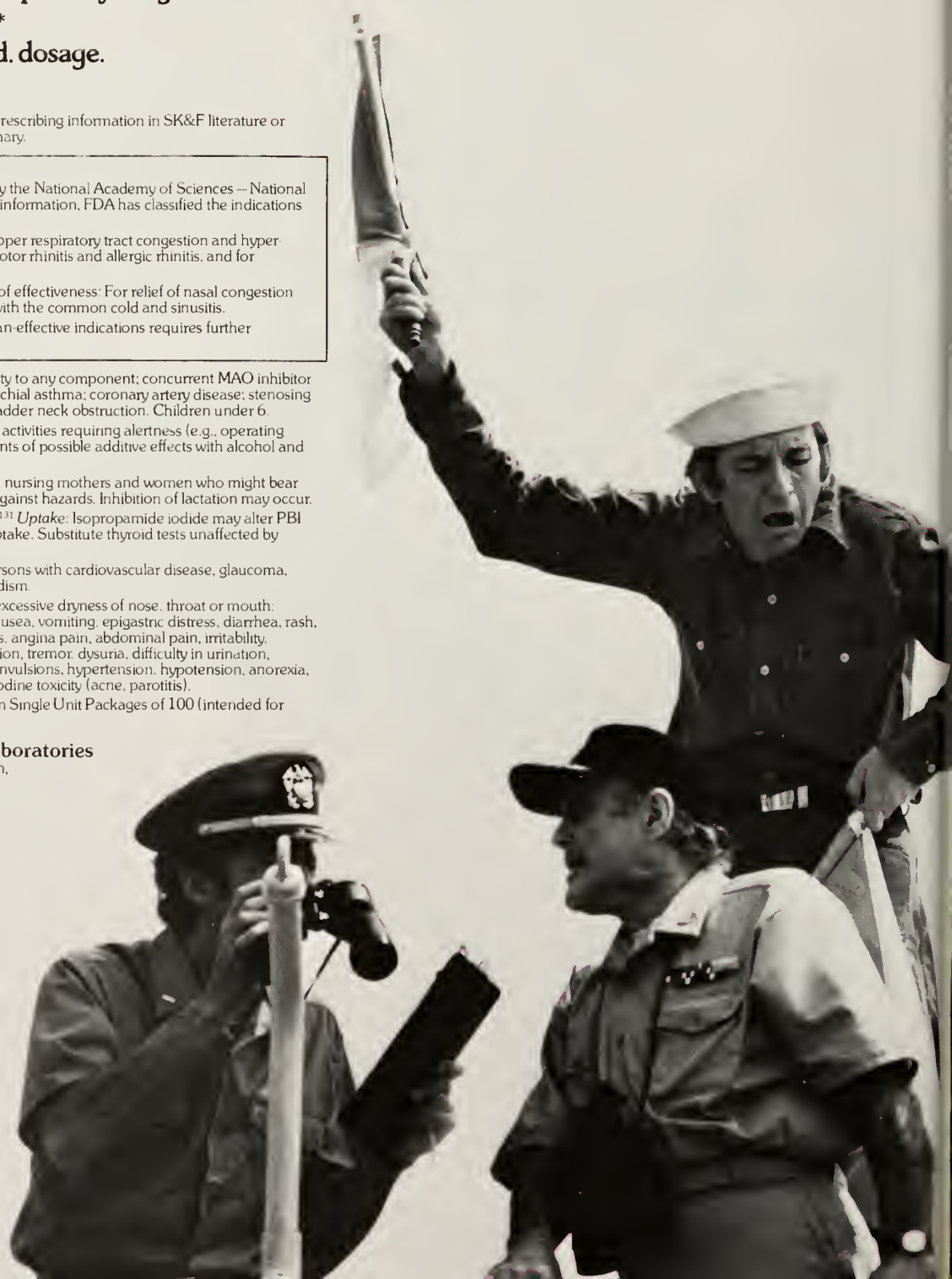
Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness, or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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Division of SmithKline Corporation,
Philadelphia, Pa. 19101



OSMA Appoints New Staff Member To Work With State Legislation

Dr. James L. Henry, OSMA President, has announced that Brent Mulgrew has joined the Columbus Headquarters in the newly-created position of Assistant Director of the Department of State Legislation. Under the Direction of Dave Rader, OSMA Legislative Director, Mr. Mulgrew will work closely with Ohio legislative processes. His responsibilities will include legislative drafting, analysis, and acting as liaison between the Ohio General Assembly and physicians.



D. Brent Mulgrew

The OSMA Department of State Legislation grew out of actions of the House of Delegates at the 1974 OSMA Annual Meeting. The House of Delegates' action had been encouraged by a message from the President emphasizing OSMA's need for two men to work with the Ohio General Assembly. "Bills with medical-health implications are introduced there by the dozens," he said. "These men must be in the House and Senate continuously, rather than dividing their time between organization duties and the Legislature."

In recent years, the Legislature has been in session almost constantly in contrast to its former record of two- or three-month sessions every second year.

Mr. Mulgrew, who joined the OSMA staff in September, will receive a Juris Doctor Degree from the Ohio State University College of Law in December, and intends to take the bar examination in March. He has considerable experience in the legislative field, making him well qualified for the new position.

He was campaign manager for Charles Rockwell Saxbe, a candidate for Ohio's 75th District Seat, contributing to his primary victory last May. As a Legislative Affairs Intern, he worked with the Ohio Council of Retail Merchants in the area of labor law, helping draft legislation and prepare testimony.

Other legislative positions held by Mr. Mulgrew include: Staff Assistant to the United States Senate Committee on Public Works (1970); researcher for the United States Department of Justice, Community Relations Division (1969); and Assistant to the Director, Department of Public Safety in Pittsburgh, Pennsylvania (1969). From 1972 to 1974, Mr. Mulgrew was a Sanitarian for the Franklin County Board of Health, giving him field work in public and environmental health in addition to administrative practice.

After graduating from Steubenville High School, Mr. Mulgrew received a Bachelor of Arts degree with honors in history and political science from Bethany College in 1971. He earned a Master of Arts degree from Ohio University the same year. Both Bethany College and Ohio University awarded History Honors Scholarships to him.

During his stay at Ohio University, Mr. Mulgrew was Assistant to the Chairman of the Department of History. From 1972 to 1974, he conducted seminars in Political, Diplomatic, European, and Russian history at Park College Branch, Rickenbacker (formerly Lockbourne) Air Force Base.

Mr. Mulgrew belongs to Sigma Alpha Epsilon, social fraternity; Phi Alpha Theta, National History Honorary; Pi Gamma Mu, National Social Science Honorary; Gamma Sigma Kappa, Scholarship Honorary; Kalon, Leadership honorary; and Phi Delta Phi, Legal Fraternity. Mr. Mulgrew was also a member of the college of Law Admissions and Financial Aid Committees, and is a Senator in the Student Bar Association.

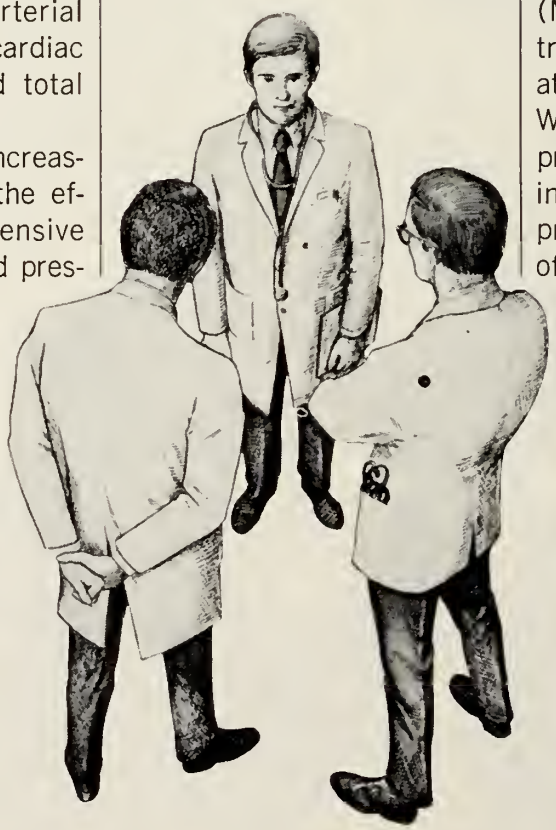
Mr. Mulgrew is married to the former Susan Weiss, who works as an Advertising Copy Supervisor for U.S. Shoe Corporation.

The Ohio State Medical Association in its role as guardian of the public health is ever ready and able to give advice or offer testimony when medical or health matters are at stake. It is very necessary that Ohio Physicians be informed when either good or bad legislation is pending so they may take whatever steps seem appropriate. OSMA's Department of State Legislation helps by keeping communications open between the Legislature and Ohio physicians.

The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

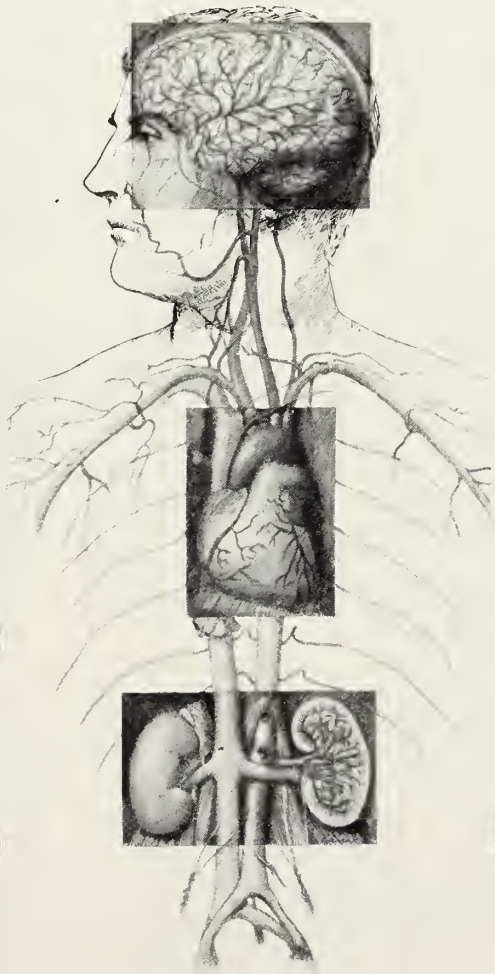


With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in

the more physicians rely on this unique antihypertensive

ing blood pressure. But
are other considerations
ll. Cardiac output is usu-
aintained with no cardiac
eration; in some patients
heart rate is actually
d. Peripheral resistance
pparently reduced.
)MET does not usually
romise existing renal
ion; it generally does not
e renal blood flow, glo-
lar filtration rate, or fil-
n fraction. And ALDOMET
ly does not cause sympto-
postural or exercise
ension.



Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

NEW now available in **500 mg TABLETS** as well as the standard 250-mg tablets

brief summary of prescribing information,
see following page.

In most cases of sustained moderate hypertension

ALDOMET®
(METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD
MERCK SHARP DOHME

"Required Reading" For Your Hypertensive Patients



Because of the importance of patient motivation, Merck Sharp & Dohme offers "High Blood Pressure," a concise, pocket-sized booklet that defines the patient's own role in the management of hypertension. This booklet is available for you to give to your patients. It is designed to reinforce your explanation of hypertension and it emphasizes the importance of patient understanding in adhering to the regimen you prescribe.

Please ask your Merck Sharp & Dohme Professional Representative or write Professional Service Department, West Point, Pa. 19486 for a supply of this booklet.

OSMA President and Health Director Confer



Health officials of Ohio and members of the Ohio State Medical Association work together on many projects since they have common interests regarding public health. This mutual effort often has been shown at the annual get-together of health officers.

At the recent 55th Annual Conference of Ohio Health Commissioners with the Ohio Department of Health, James L. Henry, M.D., President of the Ohio State Medical Association, was a guest speaker.

Dr. Henry outlined for his audience the role and functions of Medical Advances Institute. He also cited the excellent communications that exist between the State Association and the state and local health departments in Ohio.

In the above photograph, Dr. Henry, left, is confering with John W. Cashman, M.D., Director of the Ohio Department of Health. Dr. Cashman was keynote speaker for the 1974 Conference held September 11-13 in Columbus.



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Former State Association President Is Head of American Medical Association Judicial Council

GEORGE W. PETZNICK, M.D., of Shaker Heights, was unanimously elected Chairman of the Judicial Council of the American Medical Association during its 1974 Annual Convention. He first became a member of the Judicial Council in 1966, and was reelected to a second term in 1970. Dr. Petznick was President of the Ohio State Medical Association in 1961.



A family physician in the Cleveland area since 1931, Dr. Petznick has a distinguished record in medical practice, civic affairs, and medical organization work. He began his career of service to medicine by participating in numerous committees of the Academy of Medicine of Cleveland and Cuyahoga County both as a committee member and chairman. He was chosen for the Academy's Board of Directors, and in 1973 received its Distinguished Member Award.

Dr. Petznick became active at the state level in 1947 when appointed to represent the local Academy in the OSMA House of Delegates. In 1956, he became Councilor of the Fifth District, a post he held until 1960 when he was named OSMA President-Elect.

Upon completing his term as President, Dr. Petznick served for seven years as one of OSMA's delegates to the AMA House of Delegates. He was also a member of the AMA's Committee on Medicine and Religion.

As Chairman of the AMA Judicial Council, Dr. Petznick said he anticipates a very busy year, especially in the areas of medical ethics and bioethics. He summed up the challenges he faces as Chairman while addressing a recent meeting of the Florida Medical Association's Judicial Council: "Medical ethics is an ever growing, ever expanding field . . . (For example) just a few years ago no one would think of drafting guidelines for the advertising of facilities which solicit abortion "business." In the field of bioethics, he noted that "amniocentisis, fetalscopic examinations, in vitro fertilization of the human ova, the use of fetal tissue in medical experimentation and other developments, present new and perplexing ethical issues." Dr. Petznick said that while he is chairman, the AMA Judicial Council will be very involved in considering such issues which "continually rise from the inexorable advance of medical science."

Medical Care for GIs Reaches All-Time High, VA Reports

Medical care of Vietnam Era veterans is at an all-time record high with nearly 141,000 per year being treated as bed patients in the Veterans Administration hospitals.

This is about 10,000 more than in 1973 and 22,000 more than in 1972.

Outpatient or ambulatory care also is at a record level for Vietnam Era veterans, who made 2,282,000 visits to VA outpatient facilities for treatment during the fiscal year ending July 1, 248,000 more visits than in fiscal 1973.

The number of all patients treated in the 171 VA hospitals passed the million mark for the first time in fiscal 1974.

Ambulatory or outpatient clinic care soared to more than 12.2 million visits by veterans in fiscal 1974, including 10,457,573 to VA facilities and 1,808,646 to private physicians in the VA fee-for-service program.

Through a grant of $86,000 from the National Institutes of Health, studies will continue at the University of Akron on the relationship of sounds to knee-joint disease. Principals in the project are Dr. Ivan Gradisar, orthopaedic surgeon, and two associate professors of electrical engineering, Drs. Mamerto Chu and Malcolm Railey.



When a cough spoils your patient's day...

Triaminic® Expectorant

Each teaspoonful (5 ml.) contains:

Triaminic, 25 mg. (phenylpropanolamine hydrochloride, 12.5 mg.; pheniramine maleate, 6.25 mg.; pyrilamine maleate, 6.25 mg.); glyceryl guaiacolate, 100 mg.; alcohol, 5%.

Available in 8-oz. Family Size and 4-oz.
No Rx needed—recommend over the phone.

The Adult Expectorant that is great for kids, too.

Dorsey Laboratories/Division of Sandoz-Wander, Inc./Lincoln, Nebraska 68501

BS-RD

Ohio Physician Cited For Rural Health Work



Dr. Robert E. Reiheld, left, of Orrville, was recently presented with a Certificate of Appreciation from the American Medical Association for his work as Chairman of the Council on Rural Health. Dr. Julian C. Lentz, right, Council Vice Chairman, made the presentation.

Dr. Reiheld has accepted an invitation from Caspar Weinberger, Secretary of the Department of Health, Education, and Welfare, to serve on the National Advisory Council on Manpower Shortage Areas. He is a family practitioner and a Fellow of the American Academy of Family Practice.

In addition to serving since 1958 as Chairman of the Ohio State Medical Association Committee on Rural Health, Dr. Reiheld is an active member of the OSMA Committee on Mental Health. He is presently representing OSMA as chairman of a special subcommittee chosen by the Ohio Department of Mental Health and Mental Retardation to investigate the quality of medical care at the Dayton Mental Health Center.

Rural Health Conference To Meet In Roanoke, Va.

"New Approaches to Old Problems" will be the theme of the 28th National Conference on Rural Health, sponsored by the American Medical Association's Council on Rural Health.

The conference will meet Thursday, March 20 and Friday, March 21 at The Hotel Roanoke in Roanoke, Virginia. Registration fee is $40.00 (students are exempt) and includes coffee breaks, Thursday luncheon, social hour, and a cassette of Conference highlights.

The purpose of the conference is to explore new needs and report on new developments in these areas:

Family Practice Physicians' Residency Programs; National Health Service Corps, HMO's, NHI; Medical Education, Service Commitment; Rural Development and Health Services; Rural Hospitals; Student Projects; Motivations for Rural Practice; Rural Health Legislation; Emergency Medical Services; Consumer Health Education; and Community Involvement.

Ohio physicians, particularly those in the northwestern area of the state are invited to attend a Trauma Day program sponsored by Wayne State University College of Medicine in Detroit on December 6 and 7. This is the 22nd annual trauma program and is sponsored by the Michigan Committee on Trauma of the American College of Surgeons and the Department of Surgery at the University. For information and registration phone 313/961-0727.

"Gentlemen, ongratulations are in order."



"A.H. Robins asked me mpare the banana flavor of their nagel®-PG with the real thing and, ve, I couldn't tell the difference. even in sip-by-sip comparison. zing!

"There's no unpleasant goric taste because there's no goric. Clever, wouldn't you say? ad, A. H. Robins uses the thera- ic equivalent, powdered opium, omote the production of formed stools and lessen the urge. And Donnagel-PG also provides the demulcent-detoxicant effects of kaolin and pectin, plus the antispasmodic benefits of belladonna alkaloids.

"But what I find most impressive is the skillful manner in which A. H. Robins has combined these ingredients with that delicate flavor of vintage bananas. Smashing, absolutely smashing!

"May I propose a toast?"

Donnagel®-PG. ℞

Donnagel with paregoric equivalent

Each 30 cc contains:

Kaolin	6.0 g
Pectin	142.8 mg
Hyoscyamine sulfate	0.1037 mg
Atropine sulfate	0.0194 mg
Hyoscine hydrobromide	0.0065 mg
Powdered opium, USP (equivalent to paregoric 6 ml.) (warning: may be habit forming)	24.0 mg
Sodium benzoate (preservative)	60.0 mg.
Alcohol, 5%	

℞ Available on oral prescription or without prescription in compliance with applicable state and local law

A·H·ROBINS

A. H. Robins Company, Richmond, Virginia 23220


Robitussin
Robitussin-AC
Robitussin-DM
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Cough Calmers

A·H·ROBINS

IN COUGHS OF COLDS, FLU, AND U.R.I.: CLEAR THE TRACT WITH THE ROBITUSSIN® LINE

Fall and winter coughs are back. Time to help clear the lower respiratory tract with the five Robitussins and Cough Calmers. All contain glyceryl guaiacolate, the efficient expectorant that works systemically to help increase the output of lower respiratory tract fluid. The enhanced flow of less viscid secretions soothes the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Available on your prescription or recommendation.

For unproductive coughs

ROBITUSSIN®

Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg
Alcohol, 3.5%

For severe coughs

ROBITUSSIN A-C®℄

Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Codeine phosphate ..... 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control

ROBITUSSIN-DM®

Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Dextromethorphan hydrobromide ..... 15 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"

COUGH CALMERS®

Each Cough Calmer contains:
Glyceryl guaiacolate ..... 50 mg.
Dextromethorphan hydrobromide ..... 7.5 mg.

Clears nasal and sinus passages as it relieves coughs

ROBITUSSIN-PE®

Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Phenylephrine hydrochloride ..... 10 mg.
Alcohol, 1.4%

MEET THE NEWEST MEMBER OF THE LINE

Comprehensive decongestant action helps control cough and clear stuffy nose and sinuses. Non-narcotic.

ROBITUSSIN®-CF

Each 5 cc. contains:
Glyceryl guaiacolate ..... 50 mg.
Dextromethorphan hydrobromide ..... 10.0 mg.
Phenylpropanolamine hydrochloride ..... 12.5 mg.
Alcohol, 1.4%

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Obituaries

Dr. Forman, former Journal Editor, Dies at Age 87

Dr. Jonathan Forman, Columbus physician of long standing, and former Editor of *The Ohio State Medical Journal,* died on October 10 at the age of 87.

A leading Columbus editorial writer wrote of him: "Jonathan Forman wore the title of doctor because he was a physician, but more than that he was a scholar and humanitarian in every sense. He was also historian, editor, conservationist, world traveler, writer and politician."

In medicine he held board certifications in internal medicine, allergy and pathology. In education he taught pathology, internal medicine, allergy and medical history at Ohio State University and in recent years carried the title of professor emeritus.

His contributions to the medical literature ran into the thousands, and included a worldwide newsletter type of exchange between allergists. He traveled nationwide giving lectures and was called to Washington frequently as consultant in forestry, conservation, and the relationship of food to health.

Dr. Forman was primarily responsible for the continuation of Friends of the Land, a conservation organization, after the death of Louis Bromfield and the restoration of Malabar Farm. Undaunted in the face of controversy, he was an outspoken opponent of fluoridation of public water supplies.

He received his medical degree from the OSU College of Medicine in 1913 and among numerous organizations to which he belonged were the OSMA and AMA. He was Editor of *The Journal* for 23 years prior to 1958. Survivors include his widow, two daughters, a son and six grandchildren.

CORRECTION—The Journal apologizes for an error made in Dr. Skavlem's obituary in the October issue. The corrected obituary follows:

John Harvey Skavlem, M.D., Cincinnati; University of Pennsylvania Medical School at Philadelphia, 1919; aged 81; died August 7; member of OSMA and AMA.

Charles Robert Bammerlin, M.D., Centerburg; Ohio State University College of Medicine, 1953; aged 48; died August 28; former member of AMA and member of OSMA.

James Lyman Calvin, M.D., Youngstown; Western Reserve University School of Medicine, 1947; aged 50; died September 10; member of AMA and OSMA.

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Imanta V. Freimanis, M.D., Columbus; medical degree from Wuerzburg, Germany, 1962; aged 51; died September 25; member of AMA and OSMA.

Sylvester Gilbert, Jr., M.D., Springfield; Wayne State University School of Medicine, 1959; aged 50; died September 2; former member of AMA and OSMA.

Sydney Jerome Havre, M.D., Akron; Western Reserve University School of Medicine, 1913; aged 83; died September 21; member of AMA and OSMA.

John Wendell Helfrich, M.D., Coldwater; University of Michigan Medical School, 1921; aged 79; died August 31; former member of AMA and member of OSMA.

Douglas A. Johnston, M.D., Daytona Beach, Fla., formerly of Cincinnati; University of Cincinnati College of Medicine, 1914; aged 87; died August 28; member of AMA and OSMA.

Walter Byron Lacock, M.D., Columbus; Ohio State University College of Medicine, 1926; aged 76; died September 24; member of AMA and OSMA.

Walter Earl Martin, M.D., Columbus Grove; Ohio State University College of Medicine, 1938; aged 67; died September 20; member of AMA and OSMA.

David Kent Melhorn, M.D., Fremont; Western Reserve University School of Medicine, 1963; aged 37; died September 11.

William Allen Phillips, M.D., Toledo; Duke University School of Medicine, 1936; aged 68; died August 21; member of AMA and OSMA.

George Henry Quay, M.D., Cleveland; Ohio State University College of Homeopathic Medicine, 1918; aged 79; died September 26; member of AMA and OSMA.

Walter Albert Reese, M.D., Middletown; University of Cincinnati College of Medicine, 1925; aged 75; died August 29; member of AMA and OSMA.

Zenon R. Wynnytsky, M.D., Cleveland; medical degree from Munich, Germany, 1958; aged 52; died September 17.

The Joint Commission on Accreditation of Hospitals will hold a Medical Audit Team Seminar in Shaker Heights, (Cleveland) November 12-13, at Stouffer's Somerset Inn. The meeting is co-sponsored by the Ohio Hospital Association, the Cleveland Academy of Medicine, the Greater Cleveland Hospital Association, and the Northeastern Ohio Medical Records Association. The registrar is the Ohio Hospital Association, 88 E. Broad St., Columbus, O. 43215

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Cincinnati U. Establishes Family Practice Dept.

A Department of Family Practice is being established in the University of Cincinnati College of Medicine.

For a number of years the Medical Center has been working toward this step and already has several important related training programs underway. The final approval of the new department coincides with a mandate from the Ohio Legislature, passed this year, directing each of the state's four medical colleges to establish such a department.

US officials estimate that the cost will be more than $1 million per year, and expressed hope that state funding will be made available for a portion of the new costs.

Dr. Stanley B. Troup, UC Vice-President and Medical Center Director, and Dr. Robert S. Daniels, Interim Dean of the medical college, listed related new programs and commitments undertaken during the past several years:

A residency training program for emergency medicine physicians—which university officials say is the first in the nation—was established in 1971.

Faculty members, whose chief interest is in family practice and primary medical care education, service and research, are being recruited.

The Medical Center has participated in the creation of a community-owned and -operated health care network—Ambulatory Patient Care, Inc.

The Medical Center has created an area health education center in the rural area of Georgetown, Ohio.

Medical students are introduced to studies in primary care in the course offerings of the Departments of Internal Medicine and Pediatrics, and through family practice preceptorships. In this latter program, medical students have the opportunity to learn about the practical aspects of medicine and the health care needs of both rural and urban communities as they work with and observe their practicing physician-preceptors.

With the new family practice department, further academic courses can be developed and increased efforts made to recruit medical students interested in family practice. Other developments will include the establishment of primary medical care residencies including family practice, combined work in internal medicine and pediatrics, and expanded training in emergency medicine; and planning for research and evaluation programs related to the organization of medical care, its financing, and the manpower necessary to provide medical care.

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Additions to Medical Profession Reach All-Time High

Another 16,689 licensed physicians were added to the U.S. medical profession in 1973 — the largest increase in newly licensed physicians in any one year in the history of U.S. medicine.

The 15 percent increase over the number reported last year is in the 72nd annual report on medical licensure statistics by the American Medical Association's Council on Medical Education, appearing in the July 22 issue of the *Journal of the American Medical Association.*

Of this number, Ohio had 775 additions to the Medical Profession — 613 by examination, and 162 by Endorsement of their licenses to practice in other states, or National Board endorsements.

It should be noted that these are the "additions" to the medical profession. The total number of MDs licensed in Ohio during 1973 was 1,350 — 734 by examination and 616 by endorsement, according to the AMA article.

Of the 16,689 newly licensed physicians, nationwide, 7,419, or almost one half, were graduates of foreign medical schools, reflecting for the seventh consecutive year a substantial increase in the number of foreign physicians taking state board examinations.

As of December 31, 1973, there were 366,379 physicians in the United States. The total includes 326,933 licensed physicians, a net gain of 12,406 licensed physicians from the same date a year earlier, after physician losses due to deaths, retirements and return of foreign medical graduates to their homelands.

The figures should not be interpreted as meaning that only 326,933 licensed physicians are qualified to take care of patients. Thousands of physicians, working under various medical, educational and government service permits, contribute to patient care.

Radiology Efficacy Study

An extensive efficacy study has been launched by the American College of Radiology to take an in-depth look at radiological examinations because it recognizes the vital problems in American health care, two of the key ones being: The rising cost of health care and the increasing need to develop medically rational standards of care.

For more information on the study, contact Dr. Russell S. Bell, project director, efficacy study, American College of Radiology, 78 Main St., P.O. Box 859, Tiburon, Calif. 94920.

The National Cancer Institute has awarded a $200,000 grant to investigators at The Cleveland Clinic Foundation, for the study of immunotherapy in the treatment of cancer. The research team headed by Drs. Sharad D. Deodhar and James S. Hewlett will also include Drs. Ronald Bukowski of the Clinic's Department of Hematology and Medical Oncology, and William E. Braun, Head of the Clinic's Tissue Typing Laboratory. The specific type of cancer under study will be malignant melanoma.

Grant Hospital and The Grant Hospital Medical Staff will sponsor a memorial lectureship education program for physicians entitled, "Surgically Correctable Hypertension" on Wednesday, November 13, 7:30 am to 12 noon. It will be held at Grant Hospital's School of Nursing Baldwin Hall. For detail contact Grant Hospital, 309 E. State St., Columbus 43215. There will be no charge for the Continental Breakfast and the program. Reservations are not required.



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OSU Names New Chairman For Dept. of Surgery

The Ohio State University Board of Trustees has approved the appointment of Dr. Larry C. Carey, professor and vice chairman of the department of surgery at the University of Pittsburgh, as professor and chairman of Ohio State's department of surgery, effective Jan. 1.

Dr. Carey succeeds Dr. Robert M. Zollinger, who retired from the chairmanship July 1. Dr. Luther Keith currently is serving as chairman pro tem.

Born at Coal Grove, Ohio, Dr. Carey received two degrees from Ohio State: a bachelor of science in 1955 and the M.D. in 1959.

He formerly served on the Marquette University surgery faculty, the Boston University faculty, at the U. S. Navy Hospital in Chelsea, Mass., and at the Navy Station Hospital in Da-Nang, South Vietnam.

Dr. Carey became an associate professor at the University of Pittsburgh in 1969, professor in 1972, and in 1973, the vice chairman of the university's department of surgery.

He is a fellow of the American College of Surgeons and a member of numerous professional organizations.

Currently he is engaged in research projects on metabolic response to hemorrhage, funded by the U. S. Navy and conducted in the University of Pittsburgh laboratories, and on "A Simulated Clinical Low Flow 'Shock' Preparation," funded by the National Institutes of Health.

New Law To Raise Military Physicians Salaries

The recently passed Variable Incentive Pay Bill paved the way for qualified physicians in military service to earn special pay of up to $13,500 per year. Eligibility will depend on a review of each physician's particular circumstances.

The aim of the new pay bill is to reduce discrepancies between what civilian and military physicians can ordinarily earn. Differences had been greatest in the early years of practice.

Increments awarded under the bill, added to base pay and fringe payments, may often produce annual incomes that compare favorably with that of many civilian doctors—incomes in the $30,000 to $40,000 range.

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MDs in the News

Dr. Walter H. Maloney, Cleveland, was installed as vice-speaker of House of Delegates at the October 5-6 meeting of the American Council of Otolaryngology. He is associate professor and director of otolaryngology at Case Western Reserve University School of Medicine and associated with a number of area hospitals. Among other distinctions accorded him, he is a delegate to the American Medical Association Council on Otolaryngology, and secretary of the American Broncho-Esophagological Association.

Dr. David S. Yohn, director of Ohio State University Cancer Research Center, Columbus, has been elected secretary-general of the International Association for Comparative Research on Leukemia and Related Diseases. In the honorary post, he will help to organize and supervise an international symposium on comparative leukemia research to be held in Copenhagen, Denmark in the fall of 1975.

Dr. Edward L. Pratt, Cincinnati, physician executive director of Children's Hospital Medical Center, has been elected vice president of the American Pediatric Society. Dr. Pratt is also director and professor of the department of pediatrics, University of Cincinnati.

Dr. John M. Tew Jr., Cincinnati, a neurosurgeon with the Mayfield Neurological Institute, has been elected president of the board of trustees of the Ohio Division of the American Trauma Society.

Dr. James F. Leary, of Dayton, was selected by members of the 1973-74 intern-resident class at St. Elizabeth's Medical Center, Dayton, as their "outstanding teacher." Dr. Leary is a graduate of the University of Dayton and has been a member of St. Elizabeth's staff since 1961.

A former Athens physician's experiences while treating Navajo women at an Indian Health Service Hospital in New Mexico is the subject of a recent article in the *Obstetrician-Gynecologist News*. Dr. William E. Sprague, who now resides in Grand Rapids, Mich., shared obstetric responsibilities with an Indian medicine man during his two-week stay at the hospital as a volunteer obstetrician-gynecologist.

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Woman's Auxiliary Highlights

Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

THANKSGIVING, our uniquely American holiday, is fast approaching. There undoubtedly are those this year who will snort and cry; "What's there to be thankful for?" Admittedly these are difficult times and I have no wish to play Pollyanna. But why is it that we take for granted so many of our blessings, for which, rather, we should be thankful every day of the year?

That thought took hold of me very recently when I attended the conference on Immunization Action Month that was held at the offices of OSMA in cooperation with the Ohio Department of Health. The county auxiliaries had been extended a special invitation since they too had been asked to participate in this important public health project. The women were there to listen and learn about their roles and then carry the message back to their counties. The kick-off for Immunization Action Month was in October, and on a national basis. The medical profession and the public health officials have been working hard in this direction. The project has been aimed at an estimated five million susceptible pre-schoolers throughout the United States.

But isn't it something of a travesty that we have to "push" immunization, that we have to urge and remind and reeducate over and over the parents of these children to take advantage of the life-saving protection against polio, measles, rubella, diphtheria, tetanus and whooping cough? Talk about having something really to be thankful for, day in and day out! It is nothing short of irony, to my way of thinking, that the health authorities and the medical profession have to designate an Immunization Action Month to educate parents yet again, to shake them out of their lethargy and to use every medium available to get them to have their children immunized against these five serious diseases. Why all the furore? Because something has to be done to reverse the alarming trend of declining immunization levels among the one to four-year-old children. Incidentally, this campaign is not only directed at parents but at private and public health care providers.

Nothing to be thankful for this Thanksgiving? How deeply thankful we should be to medical science alone! If there were nothing else in this whole wide world for which to offer thanks this Thanksgiving (and of course there is much, much more!) it would be for this miracle of immunization. Would that we already had it for cancer and a host of other serious diseases . . . . . .

Earlier I spoke of the special conference held at the OSMA offices. It was an all-day session and included among the speakers were: John H. Ackerman, M.D., deputy director of community health, Ohio Department of Health; Robert Clinger, associate executive director, OSMA; Wesley Furste, M.D., (Dr. Furste discussed the importance of active immunization for the wounded); Antoinette Eaton, M.D. and James Giandelia, both of the Ohio Department of Health, who talked on the plan and the resources; Kathleen R. Oatman of the Ohio School Board



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Association who explained the School Board's role in immunization activities; Becky Doll (Health Department) who explained Ohio's available mass media for special programs; and Charles L. Adams, the Health Department's program coordinator for the immunization program who discussed Ohio's immunization levels and interpreted the state's immunization law. Later in the afternoon, there were several small group get-togethers.

Just a few last words on all this to our county auxiliaries: the kick-off for Immunization Action Month was in October, but the real action, the follow-up, can be any and/or every month of the year! It can be November or December — or whatever can be worked out by your particular group in cooperation with your county medical society and your health officials. Whatever you do, do get going!!

County Glimpses

Franklin County auxilians are actively participating in their community's Meals for Elderly program, operated by the Community Health and Nursing Service. The volunteers go in pairs to dispense the healthful diet trays that have been prepared at the Ohio State University Bradford Commons. They not only dispense the food but warm words and offer a listening ear to approximately 80 oldsters—ten on eight routes mostly within central city areas. These women are on hand to open milk cartons as well and to encourage eating while the food is still warm. Mrs. Donald Hoffman is chairman of this auxiliary "sharing" program.

Jefferson County's September newsletter was chuckful of "Up and Coming Events," new ideas, new committees and much, much enthusiasm! The executive board and the president, Mrs. William B. Mikita, met back in August to make tentative plans and propose recommendations for the 1974-75 auxiliary year. The first regular meeting was held on September 18 at Mrs. Mikita's home. Mrs. Carl F. Goll, loan scholarship chairman, announced that three new students selected for the loan scholarships had been accepted at the Ohio Valley Hospital School of Nursing. A tea at the Stark County Historical Center ushered in the first meeting of the auxiliary year for the **Stark County** group. Mrs. Tanya Griffith presented a fascinating story on the Duke and Duchess of Windsor.

And on this Thanksgiving of 1974 be grateful thanks to OSMA for making this column possible . . . Happy Holidays, everyone!

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FOR RENT: Sanibel, Florida condominium; 2 bedrooms, 2 baths; beachview, tennis, swimming pool, beach, shelling. Reply Box 717 c/o Ohio State Medical Journal.

PRIMARY CARE PHYSICIANS — Innovative board certified/eligible family practitioners, internists, pediatricians and emergency physicians needed to participate in progressive group practice in an academic setting. Teaching with faculty appointment. Salary/benefits very competitive. Write: James Agna, M.D., Dean's Office, University of Cincinnati College of Medicine, Cincinnati, Ohio 45267.

WANTED: Physicians throughout Ohio to do examinations for The Social Security Disability Programs. Contact John E. Hastings, M.D., Chief Medical Consultant, or Mr. Richard Leyland, Medical Administrator, 4574 Heaton Road, Columbus, Ohio 43229 or call (614) 466-3170.

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— More Classified Ads on Next Page —

CLASSIFIED ADVERTISEMENTS

(Continued from Previous Page)

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EMERGENCY ROOM PHYSICIAN WANTED. Physician needed to work in emergency room of 250 bed hospital in Marion, Ohio. Location is 40 mi. north of Columbus. Salary is $40,000 annually with excellent fringe benefit package. Contact David G. Paff, M.D., 399 E. Church Street, Marion, Ohio 43302. Phone: 614/382-1133.

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RADIOLOGISTS—175 bed community hospital Northeast Ohio in process of major expansion program including X-ray, looking for radiologists. Send resume to Box 723, c/o The Ohio State Medical Journal.

PHYSICIAN ASSISTANT

Editor's Note: The Journal presents the following classified advertisement to its readers as an announcement of the physician assistant and assumes no responsibility for the statements made.

PHYSICIAN'S ASSISTANT, 25 yrs. old with military corpsman experience. Will graduate from AMA-approved physician's assistant program associated with the Cleveland Clinic in June, 1975. Main interest, family practice or small clinic, but will consider any offer. Write to: Larry M. King, 7540 State Rd., Parma, Ohio 44134. Phone 216/886-3416.

FOR SALE, REASONABLE: Doctor leaving for Florida for health reasons, well-established active medical practice; to take over office suite of 4 rooms, fully equipped air conditioned; ample parking; St. Luke Hospital (Cleveland) area. Call 216/491-8338 from 9 a.m. to 4 p.m. or reply Box 722, c/o The Ohio State Medical Journal.

SURGEON: Board elig/cert. to join 10 member multiple specialty group in North Central Ohio near Lake Erie. E. R. McLoney, M.D., Norwalk, Ohio. Phone 419/668-4851.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.



Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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The patient may have difficulty in accepting medical counsel.

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Please see reverse side
for summary of product information.

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The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

VOLUME 70 DECEMBER 1974 NUMBER 12

DEC 26 1974

Original Articles

Goltz's Syndrome, A Case Report. Annemarie Sommer, M.D., Antoinette P. Eaton, M.D., and Stella B. Kountz, M.D. 721

Pitfalls in Paternity Testing. John W. Knox, M.D., Ph.D., Gerard E. Cote, B.S., and Muriel J. Bartles, B.S. 724

Maternal Health in Ohio: Maternal Cases Involving Carcinoma of the Cervix. By the OSMA Committee on Maternal Health 736

Special Reports

The Ohio State Medical Association Continuing Medical Education Physician Recognition Program 741

The Impact of a Computerized Peer Review System on Continuing Medical Education 748

Your AMA at Work

A Capsule Summary of Business Before the AMA House of Delegates at the 1974 Clinical Convention 752

Your State Society at Work

Consulting Medical Editor Named for the Ohio State Medical Journal 753

The Journal's Executive Editor Retires 755

1975 Annual Meeting Information 754

Notice to All Members Concerning Dues 711

Residents of Cleveland and Youngstown Receive Family Practice Scholarships 729

Keeping Up

Continuing Education Courses for Physicians Scheduled Throughout Ohio 713

Medical College Activities

University of Cincinnati Names Acting Head of New Family Practice Department 708

Wright State University Gains Two Department Chairmen 759

Public Health

Meningococcal Disease in Ohio 710

Woman's Auxiliary

Highlights 760

The Journal

The Journal's Advertisers in This Issue . . . 770

Classified Advertisements 771

Index to 1974 Issues 765

Other Features

New Members 718

Obituaries 758

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Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

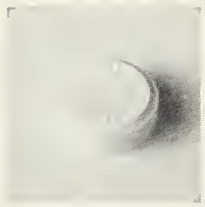
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequen and/or severity of grand mal seizures ma require increased dosage of standard an convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

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Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Ohio State MEDICAL JOURNAL

VOL. 70 DECEMBER, 1974 No. 12

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Address All Correspondence:
The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

Subscription, $5.00 per year to nonmembers; single copy, 50 cents (outside Continental U.S., $6.50 and 65 cents).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertiser must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by The Lawhead Press, Inc., Athens, Ohio

Dayton MD's Host TV Show

Physicians in Dayton have turned to television to generate consumer interest in health education.

In its third year of programming, "Medical Hotline," a 30-minute, five-day-a-week, live television show format features Dayton physicians discussing a variety of topics and answering phoned-in questions.

"Medical Hotline," co-directed by Alfred Hicks, M.D., and Stanley Sturges, M.D., is co-sponsored by the Montgomery County Medical Society and the CBS affiliate, WHIO.

Dr. Hicks, whose activities were instrumental in beginning the show, claims that "introducing our physicians into the living-room of our audience is an effective way to sell medical care."

The program has received as many as 2,000 phone calls during a 30-minute viewing time. All physician involvement in the program is voluntary.

U. of Cinn. Names Acting Head Of New Family Practice Dept.

Dr. Mary Agna, assistant dean of the University of Cincinnati College of Medicine, has been appointed acting director of the College's new Department of Family Practice.

Presently, Dr. Agna is administering a $600,000 grant obtained for the College last spring from the U.S. Department of Health, Education, and Welfare. The grant permits senior medical students to gain firsthand experience in primary-family care.

For twenty years Dr. Agna was a primary care physician practicing in rural areas. She has extensive experience in preventive medicine and public health, and was assistant health commissioner and director of medical services of the Cincinnati Health Department prior to becoming Director of the Northern Kentucky District Health Department. She has served as Health Commissioner of Clark County and of Greene County, Ohio.

The American Trauma Society, Toledo, a national voluntary health organization, has been awarded a $75,000 three-year conditional grant by the Commonwealth Fund, New York City. The Society was organized in 1971 following a recommendation of the National Academy of Sciences-National Research Council which called accidental death and disability "the neglected disease of modern society." The Society aims to establish state divisions and county units nationwide and now has 20 chartered state divisions.

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Community Health News

Ohio Department of Health

JOHN H. ACKERMAN, M.D., Deputy Director

MENINGOCOCCAL DISEASE IN OHIO

The Ohio Department of Health, Communicable Disease Division, is currently participating in a two-year national study of meningococcal disease sponsored by the Center for Disease Control, Atlanta, Georgia. The study is being conducted during months of peak occurrence in twenty eight states (56%).

The study was initiated January through March 1974 with detailed initial epidemiologic investigation of all reported cases of meningococcal disease, and follow up 30 days or more after initial investigation in order to ascertain secondary cases. The goals of the study are to characterize current practices of meningococcal chemoprophylaxis in the United States, to estimate the secondary attack rate following sporadic cases, to ascertain the overall case-fatality ratio, and identify risk factors associated with case-fatalities.

The second year of the study will begin January 1, 1975 and will continue until April 30, 1975. Upon notification of a case of meningococcal disease or a laboratory isolate of *Neisseria meningitiditis,* a member of the Ohio Department of Health will contact the physician, and explain the study protocol. With the approval of the physician, the family will be contacted and the purpose and method of the study will be explained. At this point a questionnaire will be administered to the family and the hospital record will be reviewed.

(Continued on Page 712)



DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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Notice To All Members!

Your Membership in the Ohio State Medical Association and American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA* (with other AMA publications), will expire on December 31. Here's how to renew them:

Mail your dues immediately to the Secretary-Treasurer of Your County Medical Society or to the OSMA if your County Society has chosen this option.

OSMA dues are $125.00. AMA membership dues are $110.00. Check with your local Secretary-Treasurer to determine the amount of your County Society dues. Ohio Medical Political Action Committee—American Medical Political Action Committee dues are $35. OMPAC-AMPAC membership is recommended.

Life Active membership—a category of membership approved by the 1973 House of Delegates. This membership is available to 500 physicians who make a single, lifetime dues payment of $1,250.00. When this payment is made, the life active physician is assured a full, active lifetime OSMA membership, subject only to maintenance of Ohio license and adherence to the *Principles of Medical Ethics.*

Many members probably will want to send one check to cover local, state, national, and OMPAC-AMPAC dues.

Your local Secretary-Treasurer will forward your state and national dues to the OSMA Columbus Office. That office will certify AMA dues to Chicago.

Your local Secretary-Treasurer will forward your OMPAC-AMPAC dues to OMPAC Headquarters.

As part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal* and copies of the *OSMAgram,* without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA, Today's Health,* and the *American Medical News.*

The member who becomes eligible for exemption from dues, and wishes to take advantage of exemption, should notify the secretary-treasurer of his County Medical Society. After exemption has been established, it is automatically renewed annually, unless the status changes.

(continued)

The family will be re-contacted 30 or more days after the initial contact to determine the existence of secondary cases. All meningococcal isolates forwarded to the Ohio Division of Laboratories will be sent to the Center for Disease Control for serotyping and antibiotic sensitivity testing. This testing will be performed without charge and results will be sent to the originating laboratory as soon as available.

Following is some interesting data concerning the 35 cases in Ohio in 1974:

Ohio reported 35 cases of meningococcal disease January through March 1974 which was the second highest number of cases of the 28 states. This represented 10.8% of the total of 325 cases reported in the study. The attack rate in Ohio was 0.32 cases/100,000 population/3 months of study. The median age of the Ohio cases was 2 years with a range of 3 weeks to 60 years. The case-fatality rate was 26% with 55% of deaths in children 1 year of age or less (this age group accounted for 37% of cases).

The secondary attack rate based on two cases was 15.6 cases/1,000 household members/3 months of study. Chemoprophylaxis was used in 76% of the households with a primary case of meningococcal disease. Penicillin or penicillin derivative was used in 60% of households receiving chemoprophylaxis, sulfonamide was used in 20%, tetracycline or minocycline was utilized in 16%, and cephalosporin in 4% of households.

Physicians diagnosis was meningitis alone in 47.6% of cases, meningococcemia in 47.6% of cases and both in 5.7% of cases. A majority of the deaths occurred in cases of meningococcemia as this diagnosis had a case-fatality rate of 44% compared with 6.2% in meningitis alone.

Unfortunately, in 51.4% of cases of meningococcal disease, the organism was not serotyped, and antibiotic sensitivity information is not available. The most common serotype was B which was found in 28.6% of cases. Type C accounted for 11.4% of cases, and Y was found in 8.6% of cases. The majority of isolates of serotype B were sensitive to 10 mcg/ml of sulfadiazine, as were all Y organisms, but serogroup C organisms were generally resistant. Serogroup B occurred most commonly in the age range 0-5 years, group C occurred most commonly from 5-20, and a majority of cases secondary to group Y were in adults over the age of 20.

The American College of Physicians (ACP) will sponsor a three-day postgraduate course entitled "Advances in Neurology" on January 22-24, 1975, in Seattle, Wash. Another three-day course entitled "Selected Topics in Gastroenterology will be sponsored on January 27-29 in New Orleans, La.

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Continuing Education Opportunities for Physicians in Ohio

December

If I Had an Ulcer — Steubenville Country Club; Dec. 10 at 8:15 p.m.; speaker will be Philip Thorek, M.D., Chicago; sponsored by the Fort Steuben Academy of Medicine.

A Day of Cardiology — Akron City Hospital, Akron; Dec. 18; fee is $5; contact: Institute of Medical Education, Akron City Hospital, Market and Arch Sts., Akron, 44309.

Third Annual Review Courses in Nephrology, Veterans Administration Hospital, 4100 W. Third St., Dayton 45428; 1:00 to 2:00 p.m.; contact H. Mehbod, M.D., at the center. Dec. 9, **Urinary Tract Infections and Interstitial Nephritides,** Dr. Mehbod; Dec. 13, **Kidney Stones and Obstructive Nephropathies,** Dr. Mehbod; Dec. 20, **Kidney in Heart Disease and Heart in Renal Failure,** E. Tabesh, M.D.; Dec. 23, **Cystic Diseases of the Kidneys,** Dr. Mehbod; Dec. 30, **Renal Tubular Disorders,** Dr. Mehbod.

January 1975

Family Dynamics Seminar — Marina Cay, British Virgin Islands; Jan. 4-18; sponsored by the Ohio Academy of Family Physicians.

Current Review of Upper GI Surgery—Akron City Hospital, 525 E. Market St., Akron 44309; Cosponsored by American College of Surgeons; Jan. 9-10.

Third Annual Review Courses in Nephrology, Veterans Administration Hospital, 4100 W. Third St., Dayton 45428; 1:00 to 2:00 p.m.; contact H. Mehbod, M.D., at the center. Jan. 6, **Kidney in Gout, Diabetes Mellitus, Myeloma, Amyloidosis and Collagen Disorders,** Dr. Mehbod; Jan 10, **Kidney in Liver Diseases,** G. Gourgoutis, M.D.; Jan 13, **Nephrosclerosis,** Dr. Mehbod.

Depression in the Surgical, Post-partum and Reactive Patient — Steubenville Country Club; Jan. 14 at 8:15 p.m.; speaker will be Douglas Goldman, M.D., Cincinnati; sponsored by the Fort Steuben Academy of Medicine.

A Day of Pulmonary Function — Akron City Hospital, 525 E. Market St., Akron 44309; Jan. 15.

Controversies in Surgery — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Jan. 15-16.

Family Medical Review — Sponsored by Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; Place of meeting, Imperial House North, Columbus; Jan. 11-12, and Jan. 25-26.

Gastroenterology — Sponsored by OSU College of Medicine Center for Continuing Medical Education; 320 W. Tenth St., Columbus 43210; Meeting at Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; Jan. 29.

Medical Progress for the Family Physician — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Cosponsor, American Academy of Family Practice; Jan. 29-30.

February

Renal Disease Symposium — University of Cincinnati College of Medicine, CONMED, 234 Goodman St., Cincinnati 45229; Feb. 3-7.

Urologic Outing — Hawaii; Feb. 3-19; sponsored by OSU College of Medicine Center for Continuing Medical Education, 320 W. Tenth St, Columbus 43210.

Infectious Diseases — OSU College of Medicine, Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; Meeting at Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; Feb. 5.

Sports Medicine — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Feb. 5-6.

Pressure in Anesthesiology — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Feb. 7-9.

Pediatric Workshop — Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; cosponsored by Indiana Academy of Family Physicians; at Hueston Woods Lodge, College Corner, Ohio; Feb. 8-10.

Selection of Antibiotics for Use in Infants and Children — Steubenville Country Club; Feb. 11 at 8:15 p.m.; speaker will be Henry G. Cramblett, M.D., Columbus; sponsored by the Fort Steuben Academy of Medicine.

Children, Adolescents and the Adult Psychiatrist — Marriott Inn, Cleveland; Feb. 14-16; for further information, contact Ohio Psychiatric Association, 88 East Broad St, Columbus 43215.

Electromyography — OSU College of Medicine Center for Tomorrow, 320 W. Tenth St, Columbus 43210; Feb. 17-20; fee is $225.

Physicians in Nuclear Medicine — The Nuclear Medicine Institute, Cleveland, will sponsor a 4-week continuing education course for physicians in nuclear medicine; on Feb. 17-21, March 17-21, April 14-18, May 12-16; each session is Monday through Friday; for further information, contact D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6760 Mayfield Rd, Cleveland, 44124.

Ear, Nose, Throat Disorders — Sponsored by OSU College of Medicine Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; Meeting at Stouffer's University Inn., 3025 Olentangy River Road, Columbus; Feb. 19.

Annual Infectious Disease Conference — University of Cincinnati College of Medicine, CONMED, 234 Goodman St., Cincinnati 45229; Feb. 20.

Orthopaedic Problems — OSU College of Medicine Center for Continuing Medical Education, 320 W. Tenth Ave., Columbus 43210; Meeting at the Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; Feb. 26.

Blood Bank Management — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Feb. 26-27.

March

8th Intercontinental Conference on Diagnostic Medicine — Tenerife, Canary Island; March 1-8; sponsored by Ohio Academy of Family Physicians.

Ophthalmology — OSU College of Medicine Center for Continuing Medical Education, 320 W. Tenth St., Columbus 43210; Mar. 3-4; fee is $75.

Some Thoughts on Total Care of Patients with Cancer — Steubenville Country Club; Mar. 11 at 8:15 p.m.; speaker will be Arthur J. Murphy, Jr. M.D., Pittsburgh; sponsored by Fort Steuben Academy of Medicine.

Medical Progress and its Relationship to Dentistry — Cleveland Clinic Educational Foundation, 9500 Euclid Ave, Cleveland 44106; Mar. 12-13; fee is $45.

Annual VA Hospital Symposium — University of Cincinnati College of Medicine, Office of CONMED, 234 Goodman St, Cincinnati 45229; Mar. 13.

Core Curriculum: Pediatric Echocardiography — Sponsored by the American College of Cardiology, Cincinnati, March 17-20, 1975. For details, contact: American College of Cardiology, Department of Continuing Education Programs, 9650 Rockville Pike, Bethesda, Md. 20014.

Laser Safety Short Course — University of Cincinnati College of Medicine, Office of CONMED, 234 Goodman St, Cincinnati 45229; Mar. 17-21; fee is $325.

10th Annual Cancer Symposium — Akron City Hospital, Institute of Medical Education; Mar. 19-20; fee is $10.

Recent Progress in Clinic Cancer — Cleveland Clinic Educational Foundation, 9500 Euclid Ave, Cleveland 44106; Mar. 19-20; fee is $80.

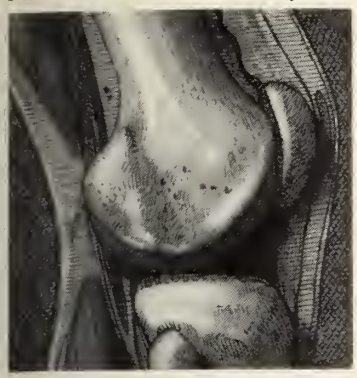
General Practice Seminar — Fawcett Center for Tomorrow, 2400 Olentangy River Rd, Columbus; Mar. 22-23; fee is $50; sponsored by OSU College of Medicine Center for Continuing Education.

May

Microneurosurgery Symposium, Cincinnati Convention Center, May 29-31, 1975. Directors: Stewart B. Dunsker, M.D., and John M. Tew, M.D. Lectures, practical demonstrations and discussions will be provided by an international faculty. Special courses for nurses and surgical assistants also will be conducted. Sponsored by the Departments of Neurosurgery, The Christ and Good Samaritan Hospital, Frank H. Mayfield,, M.D., Director. For details, write: Ms. S. Stuckey, Coordinator, Microneurosurgery Symposium, 506 Oak St., Cincinnati 45219.

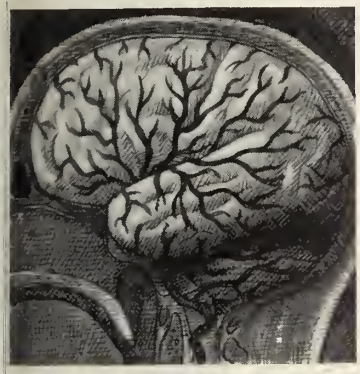
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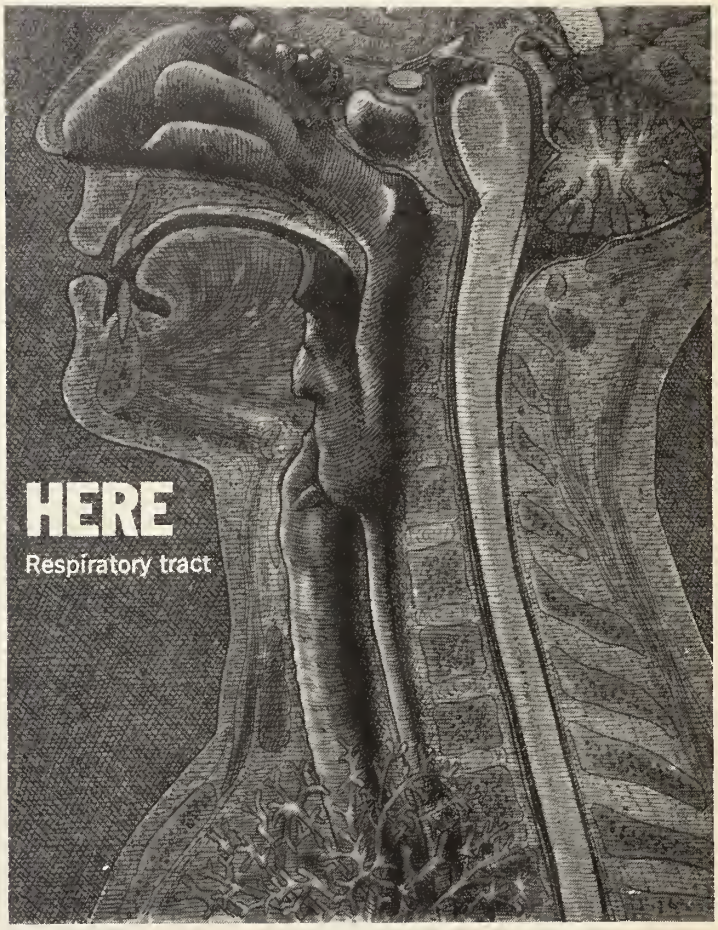


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The Role of the Detail Man

Opinion & Dialogue



Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I ar very much in favor of the detail me I meet. Most of them are knowledg able about the drugs they promote and can be a great help in acquain ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date inforrnation about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihoc on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

l He a Source of Information?

Yes, with certain reservations. Tie average sales representative h s a great fund of information a out the drug products he is re- sonsible for. He is usually able to a swer most questions fully and i telligently. He can also supply r prints of articles that contain a g eat deal of information. Here, to, I exercise some caution. I usu- ay accept most of the statements a d opinions that I find in the p pers and studies which come fi m the larger teaching facilities. It goes without saying that a physi- cin should also rely on other s urces for his information on p armacology.

Taining of Sales Representatives

Ideally, a candidate for the p sition as a sales representative o a pharmaceutical company s ould be a graduate pharmacist w o has a questioning mind. I don't th nk this is possible in every case, a d so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

c pacity they are indeed useful; p rticularly in the fact that they d seminate broadly based educa- tinal material and serve not just a "pushers" of their drugs.

T e Other Side of the Coin

Obviously, the pharmaceuti- c companies are not producing all t s material as a labor of love— t y are in the business of selling p oducts for profit. In this regard t e ambitious and improperly moti- v ed sales representative can e rt a negative influence on the p acticing physician, both by pre- s nting a one-sided picture of his p oduct, and by encouraging the p actitioner to depend too heavily o drugs for his total therapy. In t ese ways, the salesman has often d torted objective reality and u dermined his potential role as an e ucator.

T e Industry Responsibility

Since the detail man must be a information resource as well as a epresentative of his particular p armaceutical company, he s ould be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during October. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CUYAHOGA (Cleveland)
Antonio S. Daquipa
George L. Grauel
Bernardo B. Hermosura
Wook Hun Koo
Albert A. Musca
David E. Richards
Ghamartaj F. Roshan
Oscar E. Saffold
Raymond J. Votypka
Richard A. Wangelin
Robert T. Williamson
Andrew M. Zurick

ERIE
John A. Krebs
Sandusky
P. Sadasiva Setty
Huron

FRANKLIN (Columbus except as noted)
Augusto Aguirre
Donald Keith Bryan
Stephen J. Buday
Yeong Koon Chang
William U. Gibson
Sheila E. Hodgson
Charles M. Katz
Ruskin B. Lawyer, Jr.
Ali Mokhtari
Pedro J. Obregon, II
Reynoldsburg
Gary Leigh Rogers
Louis John Unverferth

HAMILTON (Cincinnati except as noted)
Bernard B. Bacevich
Gilden B. Blackburn

(continued)
Youssef T. Costandi
E. David Crawford
Daniel Dela Pava-Orrego
David F. Drake
Nageshwar P. Dwivedi
Thomas J. Fischer
Fred E. Gensler
Damrong Hadsaitong
David C. Handwerker
Sara M. Handwerker
Frank T. Jenike
Rameschchandra Kakaiya
Young Ghon Kim
Marvin Kirsh
Michael S. Kreindler
Chin Tai Lee
John R. Leikensohn
Bradley M. Lemberg
Andrew Loewy
Joseph C. McConaughy
Louis P. Meiners
David A. Milko
Luis E. Quiroga
Alvaro Restrepo
Antonio A. Rivera
Allan H. Robinson
Steve Rosenthal
James Kent Shaw
Carson Skaggs
David L. Sovine
James R. Staten
Arden H. Wander
Alexander A. Weech, Jr.
Terrace Park
Richard E. Welling
Richard J. Wiet
David K. Zipfel
Allen J. Zobay

LORAIN
Francis A. Bartek
Lorain
Y. Stanley Jung
Vermilion
Joseph R. Luciano
Oberlin
Hemendra J. Mehta
Elyria
Josef Richter
Oberlin
Carl M. Yood
Oberlin

LUCAS (Toledo, except as noted)
Louis Hacker
Gerald Katzman
Alix Rey
Elmo R. Tamayo
Donna L. Woodson
Maumee

MAHONING (Youngstown)
Howard X. Kramer
Lloyd E. Slusher

MONTGOMERY (Dayton)
James W. Bean
John R. Beljan
Don A. Marshall
David S. McLaughlin
Stephen F. Probst
Danny Lee Reveal
John M. Rich
Frances M. Unger
Peter A. Vogt

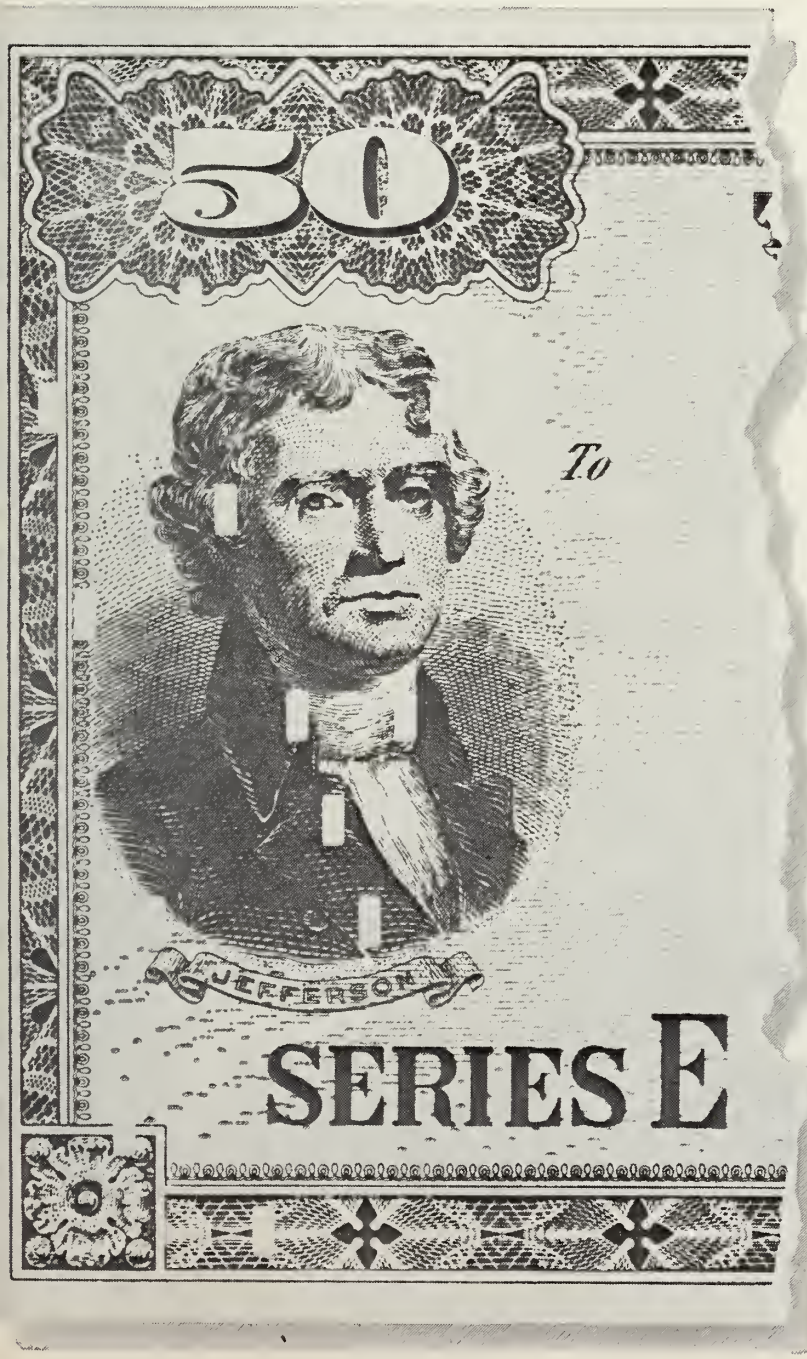
Dr. Morgan, Ninth District Councilor of the Ohio State Medical Association, has been elected to membership in the American Association for the Surgery of Trauma. Dr. Morgan served as Ohio Chairman of the American College of Surgeons Committee on Trauma for six years, and served six additional years as Chief of Section V (Ohio, Michigan, Indiana, Illinois, Wisconsin and Minnesota) of the Committee on Trauma. He currently is chairman of the Southeast Ohio Regional Emergency Medical Services Council.

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Goltz's Syndrome
A Case Report

Annemarie Sommer, M.D.
Antionette P. Eaton, M.D.
Stella B. Kontras, M.D.

THE GOLTZ SYNDROME was defined as a syndromal entity by Goltz, et al in 1962.[1] It is a meso-ectodermal disorder with focal dermal hypoplasia (FDH) being the hallmark of the anomalies.[2] Approximately 50 cases have been reported in the literature,[3] which makes this disorder sufficiently uncommon to present the case of a 5-year-old girl who was seen recently at Columbus Children's Hospital.

Case Report

This patient was first seen for evaluation at Children's Hospital at the age of 5 years.

She was born to a 27-year-old mother whose pregnancy was complicated by frequent headaches and apparent preeclampsia treated with diuretics and antihypertensives. Near-term induction of labor was attempted but was unsuccessful. The mother was then delivered by cesarean section. The infant's birth weight was 3080 gm (5 lb 8 oz). She was observed to have multiple anomalies including multiple areas of skin defects over the back, neck, and extremities, syndactyly and ectrodactyly of the hands, and an omphalocele. The latter was closed surgically in the neonatal period and the patient was discharged to the mother at 2 weeks of age.

The patient then was never seen by a physician until her present visit. According to her history, she had developed well, had not had any significant infections, and had reached the normal growth and developmental milestones at the appropriate age levels — even ahead of her sibs.

Physical examination at 5 years of age revealed a small girl in no distress (Fig. 1). She was 91.8 cm (36¾ in) tall, weighed 13.18 kg (29 lb), and her head circumference was 45 cm. She had



Fig. 1. Patient at 5 years of age. Note small stature.

From the Department of Pediatrics, Divisions of Genetics and Handicapped Children, The Ohio State University, and Children's Hospital, Columbus, Ohio.
Submitted March 21, 1974.

sparse fine hair with some areas of alopecia. There was facial asymmetry with the right half apparently smaller than the left (Fig. 2). She had colobomata of the iris, lens, and choroid of the left eye with distichiasis of the lashes. Her teeth appeared poorly formed, decreased in number, and carious. There was a 5-cm linear atrophic scar (Fig. 3) in the midline at the back of the neck and a fine atrophic scar with multiple telangiectases over the medial aspect of her right clavicular area (Fig. 4). There was an elongated surgical scar over her abdomen in the midline. The right labia majora was smaller than the left. Her right leg was 2 cm shorter than her left. There was absence of the fourth and fifth digits of the right hand and apparent partial duplication of the third digit. The left hand had five digits, but complete syndactyly between the third and fourth fingers was present (Fig. 5).

In addition, the patient had multiple areas of small scar formation and lipoid nodules over her entire body, but most pronounced over her legs (Fig. 6). A neurologic examination was normal, and psychologic evaluation resulted in an intelligence quotient of 75 but a social quotient of 91 on the Vineland Social Maturity Scale.

Multiple radiologic studies revealed the following anomalies: hypoplastic and unusually shaped teeth of primary dentition with very few crowns present for secondary dentition; a deformed right clavicle with no identifiable medial two-thirds (Fig. 7); a fusion defect of the sixth cervical vertebra and a hemivertebra in the upper thoracic spine; partial sacralization of the fifth lumbar vertebra and the right leg was 1.1 cm shorter than the left. An intravenous pyelogram was normal. Other studies which included a complete blood count, urinalysis, blood urea nitrogen, electrolytes, electrocardiogram, and chromosomes were normal.

The family history revealed no other cases of congenital anomalies. Both parents and two sibs were normal, however, the patient's mother had had one abortion.

Discussion

Goltz's syndrome is a meso-ectodermal disorder characterized by cutaneous abnormalities, skeletal



Fig. 2. Demonstration of facial asymmetry and poor dentition.



Fig. 3. Atrophic scar at upper cervical area.

Dr. Sommer, Columbus, Staff Member, Children's Hospital; and Assistant Professor of Pediatrics, The Ohio State University College of Medicine.

Dr. Eaton, Columbus, Staff Member, The Ohio State University Hospitals and Children's Hospital; and Associate Professor of Pediatrics, The Ohio State University College of Medicine.

Dr. Kontras, Columbus, Staff Member, Children's Hospital; and Professor of Pediatrics, The Ohio State University College of Medicine.



FIG. 4. Scar with telangiectases over right anterior neck.



FIG. 6. Multiple small scars with areas of protrusion of fat over the legs.

defects, ocular anomalies, oral and dental anomailes, soft tissue defects, and occasional associated defects.[4] The minimal diagnostic criteria are dermal hypoplasia with protrusion of fat, areas of underdevelopment, and thinness of the skin form-



FIG. 5. Radiograph of hands showing absence of digits and syndactyly.



FIG. 7. Chest radiograph demonstrating agenesis of right clavicle and fusion defect of cervical vertebra.

ing reticular, vermiform, cribriform, or sometimes linear streaks.[2]

Goltz's syndrome (the FDH syndrome) has to be differentiated from other diseases involving the dermal and ectodermal structures such as ectodermal dysplasia, incontinentia pigmenti, the Rothmund-Thomson syndrome, and isolated skin defect problems which commonly occur on the scalp.[5,6] However, it should be possible to arrive at the correct diagnosis on the clinical picture associated with the onset of the disease.

Our patient, although not seen by us until 5 years of age, did not have the "classical" ectodermal dysplasia since this disorder is not commonly associated with skin defects.

The diagnosis of incontinentia pigmenti is unlikely because our patient had evidence of dermal hypoplasia at birth and the skin lesions never assumed any characteristic such as vesicles or bullae.[7]

The Rothmund-Thomson syndrome usually has ocular anomalies such as cataracts, which are not usually seen in Goltz's syndrome, and associated skeletal defects are rare in poikiloderma congenitale.

Because of the small number of patients reported, the etiology of the Goltz syndrome is still unclear. Many cases have been sporadic. There is a preponderance of females over males which allows for the speculation that the disease is inherited as an X-linked dominant disorder with lethality in males,[2] the isolated male case probably representing a "Durchbrenner" which has escaped the lethality of the gene.[3]

Our case involved a little girl, and while her mother did have one miscarriage, the family history was otherwise completely negative for increased number of abortions or defects which could be manifestations of the Goltz syndrome.

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5. Holden JD, Akers WA: Goltz's syndrome, focal dermal hypoplasia, a combined mesoectodermal dysplasia. *Am J Dis Child* 114:292-300, 1967.
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Pitfalls in Paternity Testing

John W. King, M.D., Ph.D.
Geneva E. Cylar, B.S.
Muriel J. Bartley, B.S.

THE APPLICATION OF BLOOD group genetics to problems of identity and parentage is well accepted and has been of considerable help to the courts both in the United States and abroad. The technic has proved particularly useful in cases involving accusations of paternity. As generally practiced, tests are made on the blood of the child, its mother, and the accused man. The data derived from these tests are analyzed to determine if it is possible for a man having the blood types of the accused man to be the father of a child with blood types similar or identical to those found in the baby. The mother's blood types are also taken into consideration at the time of the analysis. If there is a discrepancy, an exclusion is established and reported as an exclusion of paternity. When the findings are inconclusive, they are not admissible as evidence and the only report entered in the court's record is that the tests were done.[1] The responsibility of those of us who do these tests is a very serious one, for not only may we be affecting the lives of the people involved in the study but also we may be affecting society as a whole if we err.

Ordinarily when these tests are performed, the immunohematologist places his greatest reliance on the three best known blood group systems: ABH, MN, and Rh. The Rh system is particularly useful and has a theoretical exclusion rate in a Caucasian population of about 25 percent of the exclusions demonstrated.[2] Our recently published series of 1,067 studies on a racially mixed population showed a somewhat greater rate of success, in that 40 of 108 exclusions found were determined wholly or in part by one or more of the Rh genes.[3] The Rh

From the Department of Blood Banking, The Cleveland Clinic Foundation and The Cleveland Clinic Educational Foundation, Cleveland, Ohio.

Submitted April 4, 1974.

system is relatively easy to work with and usually the careful worker can be confident of both his laboratory data and the interpretation of them. This paper is a report of a case in which there was an apparent maternity exclusion on the basis of failure to inherit e (h").

Because previous workers[4-10] have discussed problems associated with genes at this locus, we elected to investigate the problem further and have now decided to ascribe the difficulty to the occurrence of the gene $e^s(h^s)$ in the mother and child. The e^s (hr^s) antigen does not react with all anti-e (hr") sera and can be missed easily, resulting in data which can be misinterpreted, and can lead to an erroneous conclusion of exclusion of parentage.

Case Report

Mr. M and Miss B are a Negro man and woman who were involved in a paternity case and were sent to the Cleveland Clinic for blood testing. The reported data suggested a maternal exclusion on the basis of failure to inherit an e (h") gene from the mother homozygous for e. The man and woman were asked to return and bring the child, blood specimens were again taken, tests were repeated, and results were the same (Table 1).

Checking with the hospital in which the baby was born, we learned that the woman had had a baby in the emergency room of the hospital on the day in question. Because the delivery was in the emergency room and not in the delivery room, footprints were not taken of the child, but it was believed that the chance of a mistake in the identity of the child was minimal.

The possibility of fraud was considered but dismissed because there was a record of the woman having a healthy baby of the same age as the baby in question. Fraud involves an understanding of the situation which this mother did not have. She had been seen here in 1969 with another baby and another man. There was no exclusion at that time, and she had no apparent reason to feel apprehensive about the outcome of the present case.

Scoring of these three bloods for E (rh") and e (hr") for relative potency of the two antigens

Table 1. Results of Blood Tests

	Man	Mother	Child
Anti-A	+	−	+
Anti-B	−	+	+
Anti-M	+	+	−
Anti-N	+	+	+
Anti-C	−	−	−
Anti-D	+	+	+
Anti-E	+	−	+
Anti-c	+	+	+
Anti-e	+	+	−
Anti-Kell (K)	−	−	−
Anti-Duffy (Fy^a)	−	−	−

Table 2. Scoring of Red Cells for E and e Antigens

	E	e	Apparent Genotype
Accused man	¼	⅛	Ee
Mother	0	⅛	ee
Child	¼	0	EE

was unrevealing except to suggest that the child was probably not homozygous for E, as she scored no higher than Mr. M, who was known to be heterozygous for E (Table 2). It is probable that the baby is in reality heterozygous and as such she has one E (h") and one $e^s(h^s)$ gene. This would mean that the other chromosome carried a gene for $e^s(h^s)$ or that less likely, there is a gene suppression or deletion. In any case, the maternity exclusion cannot be proved and the findings were reported as inconclusive.

Discussion

In 1960 Sanger and associates[4] described a new antigen at the E locus which they call e^s or VS. The new antigen was found more frequently in Negroes than in Caucasians. Subsequently, Tippett,[5] who was one of Sanger's associates in the original paper, showed in her thesis that all anti-VS sera are not alike and show different specificity. Shapiro,[6] working with three examples of anti-VS, showed the heterogeneity of the factor among Bantu people. By analogy, he suggested that h^s, as he called it, could be regarded as the first in a series of associated blood factors related to e (hr") in the same way that Rh^A, Rh^B, etc are related to $Rh_o(D)$. Other alternative theories were also presented with the net result that the e (hr") antigen is recognized to have varying degrees of deficiency and is an unreliable antigen to use in basing a decision of paternity exclusion in studies involving people of African ancestry. Subsequently, papers by Sussman,[7] Grobbelaar and Moores,[8] and Lewis, et al[10] have confirmed the complexities of the antigen.

The incidence of exclusion based on the failure to inherit the e (h") gene must be rare. Our series shows no example of an exclusion reported on this basis.[2] Theoretically, such exclusions should be less than 0.15 percent. Eliminating these when

Dr. King, Cleveland, Clinical Pathologist at the Cleveland Clinic.

Ms. Cylar, Cleveland Heights, Senior Administrative Supervisor at the Cleveland Clinic Blood Bank.

Ms. Bartley, Atlanta, Assistant Supervisor at the Cleveland Clinic Blood Bank at the time this paper was submitted.

unsupported by other evidence is a small price to pay for bolstering confidence in our results of paternity testing.

It is important to call this to the attention of all immunohematologists who do paternity testing. The complexities of the Rh system as discussed by Race and Sanger[9] are such that references to a minor Bantu blood factor are easily missed. Had this example been seen as a paternity rather than maternity exclusion, it might well have been accepted as such and so reported to the court, resulting in a possible miscarriage of justice.

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Maternal Cases Involving Carcinoma of the Cervix

By the OSMA Committee on Maternal Health*

FOLLOWING REQUESTS and suggestions from both members of the Committee and devoted readers of this column, we are pleased to deviate slightly from the customary content and turn to the review of *nonmaternal* death cases. In the 131 preceding articles published herein, case presentations included *only* those voted as *maternal deaths* (directly or indirectly associated with the pregnant state) by action of the Committee; accordingly, preventable and avoidable factors were carefully analyzed in each death.

It has been brought to our attention that highly interesting and educational material was hidden in the cases which had *no connection* (either directly or indirectly) with the patient's pregnancy.

Therefore, from the files, the Committee offers you a new adventure associated with the Ohio Study by presenting herewith *three* nonmaternal death cases involving carcinoma of the cervix. The format of the column remains unchanged.

Case No. 134

This was a 28-year-old white, Para V, who died 5½ months after a term delivery. Past medical history

*A continuous statewide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical reports.

is unknown. Four previous pregnancies delivered viable infants, and all are surviving; no other obstetric history on the first four pregnancies was available.

During the last pregnancy, the first prenatal visit was recorded at six-months gestation. No problems or complications were recorded. Four subsequent prenatal visits were made. No bleeding or spotting was noted in the record. Last menstrual period was September 15, estimated date of confinement was June 22. "No evidence of malignancy during pregnancy," according to her physician.

Patient was admitted to the hospital at term, in labor, with history of spontaneous rupture of membranes seven hours before the onset of labor. During the first stage of labor, the patient developed secondary uterine inertia and Pitocin was administered intravenously with good results. She delivered spontaneously on July 3; no episiotomy or lacerations were noted. The infant weighed 3.6 kg (8 lb); anesthesia of cyclopropane and oxygen was given by an anesthesiologist. Placenta and membranes were complete. Length of labor was 14 hours; blood loss estimated at 300 cc. Postpartum vital signs were stable. The patient was discharged from the hospital with her baby after three uneventful postpartum days.

She was seen in six weeks by her attending physician. No problems were reported and the examination was reported as "normal." Approximately eight to nine weeks post partum, this patient was seen by another physician because of "lumbar pain." Upon pelvic examination, a suspicious small lesion was visualized on the posterior lip of the cervix. It was biopsied and revealed a pathologic diagnosis of "invasive squamous cell carcinoma/cervix." No further examination was carried out. The patient was referred to a radiotherapist who treated the patient with "irradiation," type not specified.

On December 9 (117 days post partum), the patient was admitted to the hospital in a convulsive state. Studies revealed "carcinoma of the cervix with metastasis," obstruction of the ureters, bilateral, hydro-ureters, and anasarca. She died December 27, the same year she had delivered.

Cause of Death (Autopsy): (1) Carcinoma, cervix, invasive with metastasis; (2) Hydro-ureters, bilateral; and (3) Anascarca.

Comment

By a *narrow* vote, the Committee voted this case a nonmaternal death (no connection with the pregnant state). Members made several observations after studying the case: What were findings at the *pelvic* examination (1) when the patient registered immediately post partum and at the time of examination of the cervix at the six-week postpartum visit? and (2) What type of "radiotherapy" was chosen for final treatment? There was no deliberation on preventability.

Case No. 889

This was a 29-year-old white, Para VI, who died approximately 11 months post partum. Delivery was thought to have taken place in April in another state. Patient was said to have had chronic nephritis in her past medical history. Little is known of past obstetric history except that she had six living children. The history concerning her last pregnancy was very brief and indefinite. She had onset of irregular recurrent bleeding the fourth and fifth months of gestation, which appeared without warning or cause at any time. This became more severe; details of a pelvic examination were not available.

There is no record of the date of delivery, and no description of the labor, or delivery, or of the postpartum period (another state). Approximately six months after delivery, she developed marked weight loss and complained of generalized body pain. She was using narcotics. An exploratory laparotomy was carried out (in an Ohio hospital), and biopsy was performed on pelvic tissue. Pathologic diagnosis was carcinoma of the cervix with pelvic metastasis.

Later the same month, the patient was returned to the hospital due to severe pelvic pain; it was recommended that a bilateral cervical chordotomy be carried out. This was done, but it did not give complete relief from the pain. The patient required opiates regularly. At the time of this admission, there was a suprapubic skin lesion at the lower end of the healed incisional scar; it was circular, purple in color, and the size of a dime. Biopsy revealed metastatic squamous cell carcinoma. The patient's course was downhill and she died in March, approximately 11 months after her *estimated* delivery date.

Cause of Death (Autopsy): Carcinoma, cervix, squamous cell, poorly differentiated with extensive metastasis; vesicovaginal fistula, rectovaginal fistula, obstruction of ureters, extrinsic; chronic active pyelonephritis, bilateral; hydronephrosis, hydro-ureter, bilateral; "frozen pelvis"; metastasis to lymph nodes, retroperitoneal mediastinal and cervical, liver, lungs, and left kidney; status postoperative abdominal exploratory laporotomy; status postbilateral cervical chordotomy; and status postexternal irradiation of pelvis.

Comment

After studying this case from the *meager* details available, the Committee voted it a nonmaternal death. Members regretted the very "sketchy" details recorded before the patient's first admission six months post partum. Members noted no report of examination of the pelvis (and cervix) even on this visit. And for some reason, the records reveal no consultation regarding x-ray therapy — the reason for its early rejection was not mentioned.

Case No. 1344

This was a 33-year-old white, Para V, who died eight months following delivery at 24-weeks gestation. Past medical history was essentially normal. Past obstetric history included five normal pregnancies delivered uneventfully at term with normal convalescences. With a last menstrual period of November 1, the patient registered late and her prenatal care was considered inadequate. The number of visits was not recorded. Physical examination listed as "not abnormal findings." Her last Pap smear test, made five years previous, was reported "negative."

At 22-weeks gestation, she had scanty, painless, vaginal bleeding, recurrent and irregular, cause undetermined. Two weeks later (May 11), labor ensued with uterine bleeding. Membranes ruptured spontaneously and, after ten hours of labor, she delivered a living fetus on May 12 (24-weeks gestation). There were no lacerations. No anesthesia was given.

The third stage of labor was normal — no postpartum hemorrhage. Cervical biopsy was carried out at the *time of delivery*, as a lesion was found on the lower lip of the cervix. This was described as an area of "erosion" 3 cm in diameter and very hard. Pathologic diagnosis was adeno-epidermoid carcinoma, cervix, grade IV, stage 1. Of course, an intravenous pyelogram (IVP) and barium enema were negative thereafter.

In June, the patient received a 30-treatment course of external high-voltage irradiation. In July, there was a cobalt implant with an Ernst applicator. An IVP revealed slight irregularity of the right border of the urinary bladder and indentation.

In September, the patient had a total abdominal hysterectomy, bilateral salpingo-oophroectomy, and

appendectomy. Postoperative convalescence was smooth except for backache on her left side which had been present since the cobalt irridation. She was given Robaxin.

Pathologic diagnosis: "carcinoma, cervix, post-irradiation with no residual carcinoma of cervix," stage 1, grade IV, also sciatic "herniation."

The patient was readmitted in November because of low back pain and lower abdominal cramping. The low backache was now described as a "sciatica pain." Chest x-rays revealed nodules in right and left upper lobes of the lungs suspicious of metastatic pulmonary lesions. X-rays of lumbar spine and pelvis showed a lucent defect involving the left acetabular bone. Findings from gastrointestinal and gallbladder roentgenograms were negative. Narcotics were necessary mostly for pain.

Early in December of the same year, the patient was readmitted for a "known metastatic carcinoma of the cervix." She had a partial intestinal obstruction. She was given supportive therapy, had a downhill course, and died in January, eight months after she was delivered.

No autopsy was obtained.

Cause of Death (Certificate): carcinoma of the cervix with distant metastasis, stage IV.

Comment

Noting that the records revealed excellent details, the Committee voted, by a narrow margin, this was a nonmaternal death. Members noted there was no "Pap" test or note on the condition of the cervix on her first prenatal visit (late in pregnancy). Nor was a cause for the "bleeding" shown or a note on the condition of the cervix later in pregnancy. Securing a biopsy of the cervical lesion at the time of delivery was commendable! Members wondered why the radiotherapy was delayed for a month post partum.

Comments of Consultant

The following comments of a consultant, who is a specialist in obstetrics and gynecology, were presented at the request of the Committee:

"Cancer, its early detection and its prompt treatment, is, and has been, a primary axiom for the profession and for the public. Constantly, we seek to ascertain where we have been remiss.

"Case 134: Apparently there were no Pap smears; the cervix was not examined at delivery, and the six-week examination 'was normal.' Then three weeks later, there was a 'lesion on the cervix'; the patient was referred for irradiation. Who followed up on her condition? I would figure a *pelvic cancer diagnosis delay* of at least nine weeks or more. Was the brain examined at autopsy?

"Case 889: Facts are very hazy and indefinite! There is no record of a pelvic examination until six months post partum. At laparotomy, there was a 'biopsy on pelvic tissue'; what about the cervix? Chordotomy at six months; when and where was the irradiation? I estimate a *pelvic cancer diagnosis delay* of six months, or more.

"Case 1344: The patient registered 'late' (?) and care was considered inadequate; exactly *when* did she first appear? What was found on examination for the bleeding at 22 weeks? But the cervix *was* examined and a biopsy performed at delivery. The diagnosis was cancer. Apparently the patient's radiotherapy was begun a month post partum. I wonder what the chest x-ray revealed in September, and I'm inclined to believe the malignancy was present *early*, not discovered, worsened by the pregnancy, and finally discovered at delivery. Somehow, I would vote this a *maternal* death, with *pelvic cancer diagnosis delay* of several months.

"In closing, I congratulate the Committee and its members on exploring the fascinating pathologic facts mutely contained in the *nonmaternal* cases. Otherwise, they would be lost from our enlightenment."

Generic and Trade Names of Drugs

Oxytocin injection—Pitocin (Parke-Davis)
Methocarbamol—Robaxin (A. H. Robins)

Residents of Cleveland, Youngstown Receive OSMA Family Practice Scholarships

Recipients of the Ohio State Medical Association's 1974 Family Practice Scholarships of $2,000 each are Gayle Anne Galan of Cleveland and Michael Gaudiose of Youngstown. They were selected from among 17 candidates prior to entering medical school.

This year marked the 26th annual awarding of the scholarships, designed to encourage young men and women residents of Ohio to become M.Ds. (especially family physicians) and establish their practice in Ohio. The two winning candidates were selected in competition judged on the basis of character, integrity, intelligence, mature personality, need, interest in community life, leadership and scholastic ability.

Miss Galan, 21, a graduate of James F. Rhodes High School in Cleveland, completed her pre-medical education at Case Western Reserve University last spring. She ranked first, scholastically, among 510 students in her graduating class. She entered the CWRU School of Medicine this fall.



Gayle Anne Galan

In her letter of application, Miss Galan stated that her decision to become a physician was strengthened by the lack of medical care in her home area. "In this community, composed of several ethnic groups, blacks and southern individuals, entire families go needlessly without treatment partly because of the lack of enough medical personnel, but also because they are ignorant of how and where to get medical help," said Miss Galan.

Gaudiose, 23, graduated from Chaney High School, Youngstown, in 1969, and completed his pre-medical studies last spring at Cornell University, Ithaca, New York. Gaudiose entered the Ohio State University College of Medicine in July.

Gaudiose explained in his letter of application that "above all else I am certain that I would derive a profound joy and real exhilaration from the opportunity to serve a community as a family physician." He added that family practice affords the opportunity to practice preventive medicine and to show people how to live healthfully and happily.

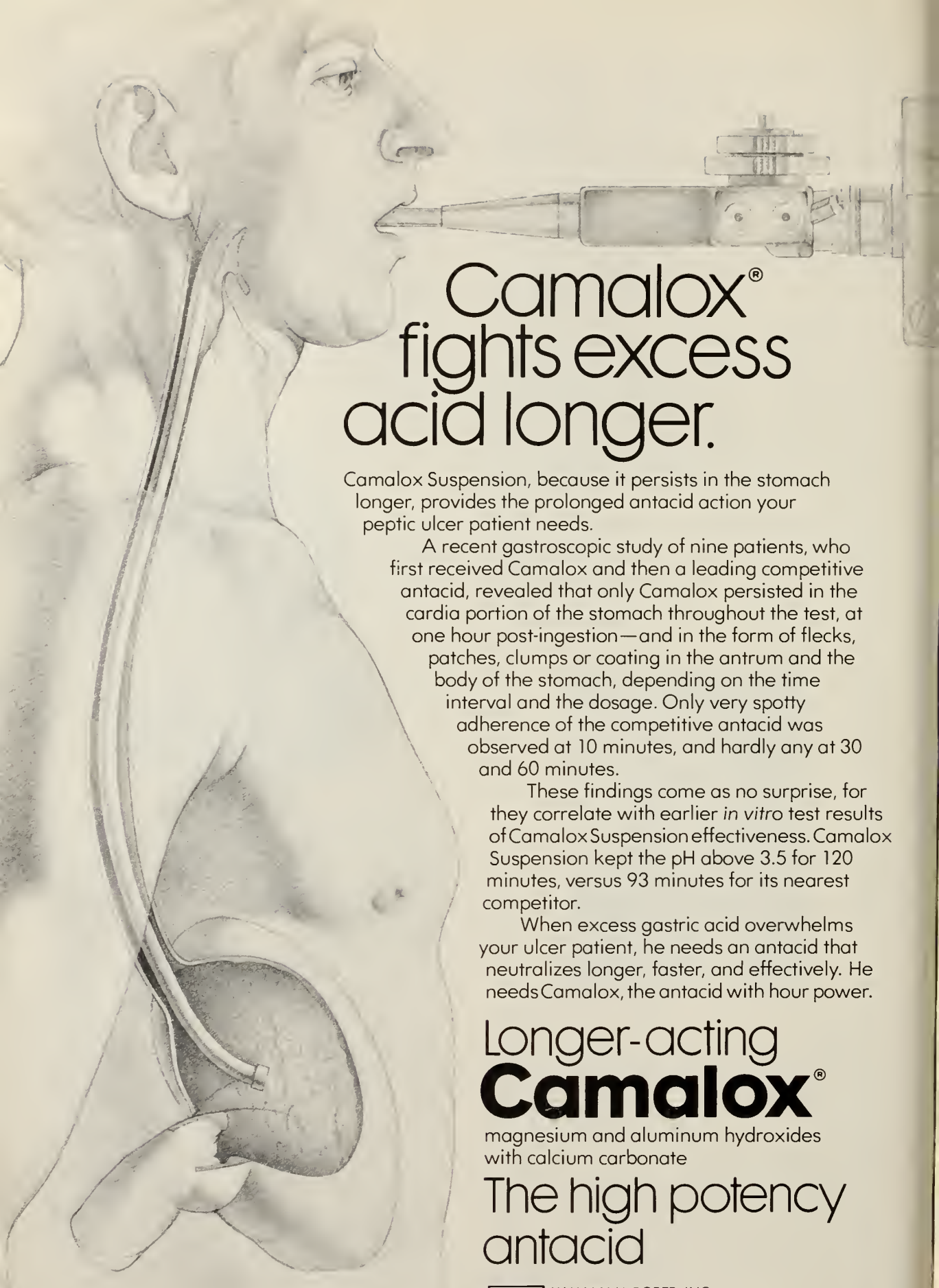


Michael Gaudiose

In addition to Miss Galan and Gaudiose, there are four medical students currently receiving the OSMA Family Practice Scholarships. They are Donald J. Kennedy, Cincinnati (University of Cincinnati College of Medicine); Carl S. Wehri, Cloverdale, (The Ohio State University College of Medicine); Mrs. Phyllis Anne Hutson, East Cleveland (Case Western Reserve University School of Medicine), and Albert J. Weisbrot, Cincinnati (University of Cincinnati College of Medicine).

Recent medical school graduates who were OSMA Family Practice Scholarship recipients include Donald M. Miller, M.D., of Upper Sandusky, who is presently in a family practice residency at Hopkins County Hospital, Madisonville, Kentucky. Following his residency, Dr. Miller plans to enter family practice in Fostoria, Ohio. Dr. Miller received the scholarship in 1971.

John E. Pappas, M.D., of Cuyahoga Falls, one of the 1970 scholarship recipients, is interning at the University Hospital in Lexington, Kentucky. The other 1970 winner, John H. Surry, M.D. of Youngstown, is in residency at Lancaster General Hospital, Lancaster, Pennsylvania.



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The Ohio State Medical Association

Continuing Medical Education Physician Recognition Program

"Continuing medical education is defined as educational activities designed to reinforce the physician's basic medical knowledge and inform him of new developments within his field through refresher and supplemental courses. These programs do not lead to any formal, advanced standing in the profession."
—American Medical Association **Topics,** 1972

The important role of the state medical association in relation to the continuing education of its members was recognized at the national level at the First Biennial Conference on Continuing Education sponsored by the American Medical Association, in 1968. In succeeding Biennial Conferences, the scope and depth of state medical association involvement have been extended progressively.

At present, 28 state associations are approved as accrediting bodies for continuing education activities in their respective states. Moreover, the AMA is developing plans for tabulation and analysis of individual physician participation in continuing education, in cooperation with the state associations.

For the past two years, your OSMA Commission on Medical Education has been working on these two important facets: (1) a program that would give recognition to physicians' participation in CME; (2) a program for accrediting institutions and organizations in Ohio that provide Continuing Medical Education. The OSMA House of Delegates directed that this be done.

The plans detailed in the following pages represent the culmination of the Commission's efforts to establish these programs for the OSMA membership. Approval by OSMA Council and anticipated approval by the AMA Council on Medical Education make an implementation date of January 1, 1975 a realistic projection.

We urge your thoughtful consideration of this material, and, subsequently, your active participation. As a result, our primary goal — quality patient care through quality continuing education — can be achieved more effectively.

Howard S. Madigan, M.D.
Chairman, Ad Hoc Committee on
Accreditation/Recognition Programs
Commission on Medical Education
Ohio State Medical Association

THE Ohio State Medical Association House of Delegates, at the 1973 Annual Meeting, instructed the Commission on Education to develop a program to formally recognize voluntary participation in continuing medical education on the part of members of the Association.

NAME OF PROGRAM: "The Ohio State Medical Association Continuing Medical Education Physician Recognition Program."

PURPOSE: To give appropriate recognition to those members who periodically meet the program's continuing education requirements, such recognition to be made in periods of three years.

REQUIREMENTS FOR RECOGNITION: Participation in **150 credits** of any of a number of types of continuing education experiences in a three-year period, and documentation provided to the Association.

ALTERNATE SATISFACTION OF REQUIREMENT: Qualification of the continuing education program of the member's national specialty society, or national specialty board; recertification by his national specialty society, or specialty board; provided that such qualifications are not less than the requirements of the OSMA program; qualification for the American Medical Association Physician Recognition Award. The member is to submit documentation of such qualification under this section to the OSMA.

CATEGORIES OF ACCEPTABLE CONTINUING MEDICAL EDUCATION EXPERIENCE. Credits may be obtained through participation in the Acceptable CME Experiences listed herein.

At least 60 credits **must** be earned in Categories 1, 2 and 3.

The total 150 credits **may** be earned in Categories 1, 2 and 3.

Acceptable CME experiences:

Category 1: A recognized Ohio State Medical Association scientific meeting, or a recognized national scientific meeting: **One credit for each hour of attendance.**

Category 2: Scientific meetings conducted by county medical societies, hospital medical staffs, state, regional or local specialty societies or professional service review organizations. **One credit for each hour of attendance.**

Category 3: Accredited programs planned and presented as specific continuing medical experiences. **One credit for each hour of attendance.**

Category 4: Part-time teaching. **One credit for each hour of teaching. Limit: 90 credits for three years.**

Category 5: Part-time research. **One credit for each hour of investigative work. Limit 60 credits for three years.**

Category 6: Preparation and presentation of a scientific paper or a scientific exhibit at a medical meeting; publication of a scientific paper in a scientific periodical or recognized medical journal. **Ten credits.** (When prepared by more than one physician, the credits shall be prorated among those physicians.) **Limit: 30 credits for three years.**

Category 7: Participation in a professional self-assessment program, and engaging in continuing education experiences as a result of the self-assessment program. **One credit for each hour of participation.**

Category 8: Serving as a personal preceptor to a preceptee who is a medical student, intern or resident. **One credit for each 4 hours of serving.**

Category 9: Serving as a member of The Council, an OSMA committee, commission, or as a member of a scientific PSRO council. **One credit for each two hours of regular meetings. Limit: 30 credits for three years.**

Category 10: Audiovisual methods

A. Radio or television CME programs presented by accredited organizations or institutions. **One credit for every two hours of participation.**

B. Audio and/or video tape/cassette or slide-tape programs prepared or sponsored by a recognized medical organization, a medical school or recognized producer of medical education materials, with individual or group participation. **One credit for every two hours of participation. Limit: 60 credits for three years.**

Category 11: Self-study, such as reading professional journals, monographs, texts, etc. **One credit for every two hours of participation. Limit: 90 credits per three years.**

Participating physicians will be required to submit annually a report of their CME activity for the preceding 12 months, utilizing forms provided by the OSMA Commission on Education. The three-year cumulative record will be the basis for physicians' periodic recognition of CME participation. Additionally, it will facilitate remedial efforts, as may be necessary to encourage more meaningful CME participation during the course of a given three-year period.

An integral part of the reporting system will be the individual "CME Diary," designed for day-to-day use by the physician. Monthly and annual summary forms will be included, and provision made for participants to retain a personal copy. The latter may be used to meet requirements of other organizations or societies.

At the end of each three-year period, physicians' CME records will be reviewed by the Commission and appropriate recognition of their CME participation recommended to the Council. Upon official OSMA approval, a certificate will be issued to the qualifying physician.

Plan of the Ohio State Medical Association for Accreditation of Institutions and Organizations with Continuing Medical Education Programs

This document outlines the plan which the Ohio State Medical Association wishes to develop and implement, and will serve as part of the Association's application to become an accrediting body for institutions and organizations in the State of Ohio which provide local/regional continuing medical education programs.

The Ohio State Medical Association wishes to conduct a voluntary accreditation program, within the State of Ohio, for community hospitals and other institutions/organizations providing continuing education for physicians on hospital staffs and in local communities.

If approved by the AMA Council on Medical Education, the Ohio State Medical Association plans to focus its accreditation program upon the following categories of institutions and organizations:

1. Hospitals which have continuing medical education activities limited to hospital staff and physicians in the local community.
2. Medical organizations which do not have national scope, e.g. county or other local societies.
3. Local/regional units of voluntary health organizations not under national administration for their continuing medical education.
4. Other institutions or organizations which sponsor or promote continuing education for physicians, essentially local/regional in nature, appropriate to the needs of the profession.

The Ohio State Medical Association will seek accreditation from the AMA Council on Medical Education for its own programs of continuing education.

The Ohio State Medical Association will use the standards as set forth in the **AMA Essentials of Approved Programs in Continuing Medical Education** in its accreditation program.

A budget for the accreditation program will be developed.. Income to provide for this budget will come from fees charged applicant institutions/and organizations which desire surveys and from the Association treasury. Staff assistance will be provided by the Association through addition of an administrative assistant for the program.

A roster of potential surveyors will be developed, to be used in the accreditation program. These will include hospital directors of medical education, medical school faculty with expertise in continuing education, specialty society experts and voluntary health organization individuals with knowledge and experience in continuing medical education.

A mechanism will be developed to allow any institution or organization which is dissatisfied with its survey or accreditation action to appeal thru the Commission on Medical Education and the Association Council. Any institution or organization which is denied accreditation shall have the reasons for non-accreditation provided to it. These reasons will, in general, conform to the Essentials.

The Commission on Medical Education, or a committee thereof, will be responsible for operating/managing the accreditation program, and for providing consultative services to institutions and organizations desiring to establish a continuing medical education program based upon accepted Essentials.

The primary goal of this accreditation program will be to identify and document programs of continuing medical education in Ohio that satisfy the **Essentials of Approved Programs in Continuing Medical Education.** It is our belief that such accreditation may serve as an incentive to the institutions and organizations to provide programs that are based on actual and determined education needs of physicians; that are developed on sound educational principles; and, that will be evaluated in terms of their effect on improvement of patient care.

In implementing the accrediting system, and prior to any survey, a preliminary assessment will be made of the institution or organization seeking the survey, to ascertain that it has:

1. Sufficient, qualified leadership and strong institutional commitment to continuing education.
2. Written objectives for its continuing education program, designed to improve physician competence and quality of patient care.
3. A realistic budget.
4. Competent teachers.
5. A continuing education program/curriculum of appropriate depth and scope to meet the education needs of the physicians.
6. Suitable participative educational methods.
7. Adequate equipment (audio-visual and other) and facilities for continuing education.
8. Some acceptable method of audit or quality of care evaluation to determine the extent to which the continuing education program has accomplished its goals and objectives.

Accreditation Manual for Continuing Medical Education Activities in Ohio

OHIO STATE MEDICAL ASSOCIATION COMMISSION ON MEDICAL EDUCATION

600 S. High Street
Columbus, Ohio 43215

FOREWORD

The purpose of this Manual is to assist the medical staff of community hospitals, other institutions and organizations to develop effective continuing medical education.

The concept of 'lifetime learning' has become an accepted fact among practicing physicians; indeed a necessity, in order to maintain a level of competence that will insure quality patient care. The Ohio State Medical Association, in cooperation with the American Medical Association, is undertaking a voluntary program of recognition of physicians for the completion of minimum requirements of continuing medical education in an effort to implement the concept of lifetime learning.

Despite the large number and variety of courses and programs currently offered, it is apparent that there is need to improve accessibility, methodology, relevance and quality of continuing medical education. This is essential if practicing physicians are to meet effectively the health care needs and demands of our population. An important corollary activity is evaluation of the effectiveness of the educational effort by review of the quality of medical care, to detect changes in physician performance.

The Ohio State Medical Association, in cooperation with the American Medical Association, will survey (through questionnaire and site visits) and accredit continuing medical education activities for hospitals and other organizations which seek accreditation. The principles described in this manual are the general statement of criteria to be used by survey teams in assessing the quality of the educational efforts. These criteria are flexible and will be reviewed periodically. From time to time, material containing practical suggestions for determining educational needs and for the planning and evaluation of programs designed to meet these needs will be provided.

ADMINISTRATIVE POLICIES

Survey Eligibility

To be eligible for an accreditation survey, the following standards are deemed as critically important aspects of a hospital's or organization's commitment to improving patient care through continuing medical education.

Standard 1: Administration

A. There shall be explicit support of continuing medical education by the governing body, organized medical staff and administration through a continuing medical education committee having cross membership with patient care review committees and including a wide range of subspecialties and departmental representation.

B. There shall be a responsible educator-in-chief with supporting staff, including availibility and use of expert knowledge of educational methods whenever practical.

C. There shall be evidence of coordination and cooperation with other educational programs in the area in sharing resources and evidence of efforts to meet educational needs of physicians in the community.

Standard 2: Budget

A. There shall be evidence of financial support through provision of a budget for continuing medical education of the attending staff.

Standard 3: Teaching Staff

A. There shall be evidence of a commitment from physicians of proven ability, training and experience with an interest in and dedication to the development of carefully planned educational programs.

Standard 4: Curriculum

A. There shall be a mechanism of need assessment as developed through quality of patient care review mechanisms.

B. There shall be a method of preparing clearly defined objectives for each educational activity based upon these need assessment procedures.

Standard 5: Facilities

A. There shall be adequate facilities that encourage participative methods of education.

Standard 6: Educational Methods

A. There shall be planned learning experiences designed to achieve the specific objectives; selecting the most effective educational method for the particular need; whether knowledge, skill, attitudes or performance are to be changed.

Standard 7: Methods of Evaluation

A. There shall be evaluation of each individual educational activity of the entire continuing education program of the institution in terms of impact on the quality of patient care through review procedures similar to those followed in assessing needs.

Standard 8: Physician's Reward

A. Each physician's reward for participation in continuing medical education should be his improved ability to care for his patients and the stimulation of his own spirit of intellectual adventure.

Survey Personnel

- A site team composed of three persons will conduct surveys:
  - (1) an experienced site visitor
  - (2) a neophyte or first-timer for a site accreditation visit
  - (3) a representative of the local county medical society
- The amount of time spent in conducting the survey of each institution shall be determined by the Commission on Medical Education, but it is expected that each site visit will be of one-day duration.

Survey Fees

- A survey registration fee of $50 will be charged by the OSMA for administrative work connected with site visits. This shall be paid in advance at the time of submission of the pre-survey questionnaire. If the institution is not surveyed, the fee will be refunded.
- The expenses of the site visitors, to include travel and food, will be covered by the institution requesting accreditation. These expenses will be based upon actual cost as determined following the site visit and paid to the site visitors directly. It is anticipated that no institution will have to pay more than $200 for a site visit, in addition to the $50 paid to OSMA.

Accreditation and Duration

- Each institution or organization that has been surveyed will be notified by the Commission on Medical Education whether or not it has been accredited.
- Types of Accreditation
  - (1) Accreditation of the institution or organization
  - (2) Accreditation of the institution or organization contingent upon stipulated changes in the program. Accreditation granted when contingent is met (this classification applies in those cases where the program does not meet the requirements for accreditation, but seems to have the potential for doing so) would be for a limited time only, and a resurvey would be made within a stated period of one or two years.
  - (3) Provisional accreditation of an institution or organization. (applicable only to newly developed programs and with a time limit of one or two years)
  - (4) Accreditation only of certain courses within an institution or organization, rather than the entire institution. (This classification is to be given in cases where courses given by one department or branch are of high quality and those given by another area of the institution or agency are not of satisfactory quality for accreditation.)
  - (5) Nonaccreditation of the institution or agency. In such cases, reasons for the recommendation will be given.

Accreditation Decision and Appeal

- At the completion of the survey visit, a site team will hold a summation conference and submit its recommendations to the Commission on Medical Education.
- The Commission on Medical Education shall make a decision.
- A decision of the Commission to deny or revoke accreditation because of recommendations of the site team shall entitle the institution or organization to provide additional information and further clarify the findings pertaining to the decision.
- If accreditation is denied, an appeal in writing may be submitted to the Commission on Medical Education with supporting information and data, questioning the recommendation, and requesting reconsideration of the accreditation.

Public Recognition

- A certificate of accreditation shall be provided to an institution or organization that is granted accreditation. The certificate shall specify the type of accreditation and the years for which it is granted.

• The institution or organization will be entitled to indicate on continuing education programs the type of accreditation approved for their institution and the category in which it is given.

For answers to specific questions write:
Commission on Medical Education
Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

PREAMBLE*

The ultimate aim of continuing medical education is improvement of the health and well-being of the individual patient and of the public. This may be accomplished by bringing about:

1. Changes in the attitudes of physicians
2. Correction of outdated knowledge
3. Introduction of new knowledge
4. Mastery of specific skills and techniques
5. Improvement in the performance of the physicians

It is presumed that the accomplishment of these measurable objectives will alter the physician-learner's habits in a favorable direction which can be evaluated by a systematic assessment of the quality of medical care provided within the hospital. Each medical staff should develop empiric evidence of educational needs through internal self-evaluation of the quality of medical care. This will allow a clear statement of the specific objectives of the educational program and permit evaluation of its effectiveness. Imaginative and innovative techniques to accomplish these objectives should be encouraged.

Standards and Interpretation for Accreditation of Community Continuing Medical Education Activities

STANDARD 1 — ADMINISTRATIVE

A. There shall be explicit support of continuing medical education by the governing body, organized medical staff and administration, through a continuing medical education committee having cross membership with patient care review committees and including a wide range of subspecialties and departmental representation.

Interpretation

There should be administration of continuing education by a responsible person, having the respect and support of the medical staff and hospital administration. The goal should be a program of the highest value to the public and medical profession. There must be continuity of administration, advance planning, evaluation, and feedback from physician-learners and teachers. This cannot be accomplished by the appointment or election of the chairman of the educational committee on a yearly basis as is commonly done by the medical staffs of community hospitals. Many hospitals have found it necessary to employ a physician, either full- or part-time, as director of medical education because the burdens of this position can become too great to be carried by a volunteer member of the medical staff. Cooperative arrangements through the county medical society could be made by hospital medical staffs on a regional basis to share such leadership.

B. There shall be a responsible educator-in-chief with supporting staff, including availability and use of expert knowledge of educational methods whenever practical.

Interpretation

The chairman of the continuing medical education committee, director of medical education, or "educator-in-chief," should be charged with the following responsibilities:

(1) Determine the specific needs of the medical staff as developed by systematic assessment of the quality of medical care conducted by the tissue, audit, utilization, and records committees, or by a special "educational audit" committee.

(2) Provide clear statements of the objectives of specific educational activities.

(3) Plan activities well in advance.

(4) Encourage involvement of all members of the medical staff throughout the educational process by enlisting their help in the determination of needs, the development of objectives, implementation, teaching, learning, and evaluation.

(5) Insure that study areas, audiovisual and self-instructional aids are available.

(6) Publicize the continuing medical education effort to the medical staff and to the general public.

(7) Supervise enrollment records.

(8) Coordinate educational activities for physicians with programs for allied medical personnel.

(9) Plan for evaluation of the effectiveness of the program to see if the objectives are being accomplished.

(10) Encourage the provision of adequate library facilities and services.

*Assistance of the Pennsylvania Medical Society CME program is appreciated.

C. There shall be evidence of coordination and cooperation with other educational programs in the area in sharing resources and evidence of efforts to meet the educational needs of physicians in the community.

Interpretation

Through cooperative arrangements, coordinated by the local county medical society, the following goals should be attempted:

(1) Coordinate educational activities with other programs of continuing medical education in the community.

(2) Develop strong working relationships with continuing medical education departments of nearby medical schools.

STANDARD 2 — BUDGET

A. There shall be evidence of financial support through provision of a budget for continuing medical education of the attending staff.

Interpretation

The budget should be adequate for the educational activities and for their continued improvement. Sole dependence upon tuition fees will restrict the quality, breadth, and depth of the educational program. Support for these activities may be sought from medical staff dues, hospital general funds, voluntary health agencies, federal funds, existing charitable foundations, or by the development of new hospital research and education foundations.

STANDARD 3 — TEACHING STAFF

A. There shall be evidence of a commitment from physicians of proven ability, training and experience with an interest in and dedication to the development of carefully planned educational programs.

Interpretation

The teaching staff may consist of physician members of the hospital medical staff. Frequently it is desirable to enlist teachers from other hospitals and medical schools, although the main body of teaching should come from within the region. There must be an adequate number of teachers capable of explaining the basic mechanisms of disease and their clinical applications in prevention, diagnosis, and treatment. Not all physicians are good teachers, but all teachers can be improved through helpful criticism of their efforts by physician-learners. Those community hospitals with intern and residency programs should have a nucleus for a faculty that can be expanded to meet the demands of a solid continuing medical education program. In order that each community hospital may obtain necessary academic support for their programs of continuing education, it is suggested that cooperation with medical schools or larger hospitals be established.

STANDARD 4 — CURRICULUM

A. There shall be a mechanism of need assessment as developed through quality of patient care review mechanisms.

Interpretation

Thoughtful planning requires that the content of the educational activities be based upon the demonstrated needs of the learners and relevant to their work within the hospital.

B. There shall be a method of preparing clearly defined objectives for each educational activity based upon these need assessment procedures.

Interpretation

The means of establishing needs may vary but must be more than a popularity poll. Newer knowledge of the basic mechanisms of disease and treatment should be an integral part of the program along with more practical information. The curriculum should be coordinated with other hospitals and/or medical schools to avoid duplication and encourage adequate coverage.

STANDARDS 5 — FACILITIES

A. There shall be adequate facilities that encourage participative methods of education.

Interpretation

There should be facilities available that encourage participative methods of education. Though lectures are means whereby physicians obtain information, it is felt that this method of education alone cannot provide an adequate continuing education program in the context of modern education. The facilities, as appropriate to the content of the program, should include the availability of patients and their case records and other necessary records such as roentgenograms, electrocardiograms, surgical pathology tissues or reports, laboratories, library, adequate conference rooms, and audiovisual aids.

STANDARD 6 — EDUCATIONAL METHODS

A. There shall be planned learning experiences designed to achieve the specific objectives; selecting the most effective educational method for the particular need; whether knowledge, skill, attitudes or performance are to be changed.

Interpretation

The educational methods should include more than a series of lectures or panel discussions in which the physicians are primarily passive recipients. Methods requiring active participation

include live clinics and bedside rounds, seminars, open question periods, laboratory work, and the study of patients under supervision. There is ample evidence in the undergraduate and graduate phases of medical education that overemphasis on purely didactic methods results in less learning than one requiring active participation. It should be noted that any potentially active method of education, such as ward rounds, can become a purely passive exercise if the group is too large. Bedside groups of six or eight physicians would be likely to encourage participation of each, while bedside groups of more than ten might easily consist of "standing lectures." Strictly as aids to education rather than as the sole method, the use of slides, motion pictures, and television is encouraged. In the case of home study courses, the use of audio-visual kits may be of value. Such tools as television and videotape have valuable and even unique potentialities when their usefulness is appreciated as means rather than as ends. When lectures are utilized, it is helpful also to conduct group discussions and question and answer sessions as follow-through techniques. Similarly, though appropriate audiovisual aids are of assistance, they should be simply a part of and integrated into planned educational activities. Problem patients of physicians on the attending staff of community hospitals can be utilized in a program of continuing medical education if other facilities and a teaching staff are provided. Such education, if carefully planned and enthusiastically put into effect by the attending staff of the community hospital, would be more truly continuous education and thus more valuable than is likely to be the effect of sporadic study of informal courses.

STANDARD 7 — METHODS OF EVALUATION

A. There shall be evaluation of each individual educational activity of the entire continuing education program of the institution in terms of impact on the quality of patient care through review procedures similar to those followed in assessing needs.

Interpretation

Methods of evaluating the effectiveness of continuing education should be developed. Without an initial statement of specific objectives for each activity, it is difficult if not impossible, to ascertain in any meaningful way whether such objectives have been fulfilled. Yet, evaluation of each program and its students' achievements, both immediate and long-range, is essential. Experiments directed toward better ways of accomplishing such evaluation are encouraged. Since the goal of all these efforts is better patient care, each hospital should try to ascertain whether the educational program has in fact improved the quality of medical care. The systematic evaluation of the quality of medical care has excellent educational possibilities when conducted as "educational audit."

STANDARD 8 — PHYSICIAN'S REWARD

A. Each physician's reward for participation in continuing medical education should be his improved ability to care for his patients and the stimulation of his own spirit of intellectual adventure.

Interpretation

Any certificate granted at the completion of a continuing education program or series of programs should not be, nor resemble, a diploma attesting to special skill nor be reasonably susceptible to such interpretation. Continuing medical education is not intended to provide an educational experience adequate for beginning the practice of a specialty or subspecialty — that is the concern of graduate medical education, i.e., residency and fellowship training. Therefore, it would be inappropriate for any document attesting to continuing education study to be subject to misinterpretation. The Ohio State Medical Association and the American Medical Association have established certification for physicians who have completed certain minimum requirements of continuing medical education. It is hoped that many community hospitals in Ohio will develop activities that may be accredited so their medical staff members can obtain much of their education in their own hospital.

SUMMARY

These guiding principles were developed to:

1. Assist medical staffs of community hospitals in the production of continuing medical education activities.
2. Improve the educational worth and relevance of continuing medical education activities.
3. Outline mechanisms for evaluating the effectiveness of continuing medical education.
4. Provide a basis for the accreditation of continuing medical education activities in community hospitals.
5. Outline a plan for Ohio State Medical Association "Survey Teams" to use in examining the approach of community hospital medical staffs to continuing medical education.

The basic principles of continuing medical education are the same as are those of undergraduate or graduate medical education. An effective program requires leadership, careful planning, suitable facilities, and competent teachers who use dynamic methods of education that enlist the participation of the student. Appropriate means of evaluation should be devised to permit some measure of the program's effectiveness.

OHIO STATE MEDICAL ASSOCIATION
600 South High Street • Columbus, Ohio 43215
(614) 228-6971

Commission on Medical Education
ACCREDITATION OF CONTINUING MEDICAL EDUCATION
PRESURVEY QUESTIONNAIRE

Name of Hospital _____

Submitted by _____ Date _____
(Name of Individual)

_____
(Title)

Introduction:

This questionnaire will serve as an inventory of educational facilities and activities in the hospital. It will provide the background information for the survey team which will visit the hospital. It should be appropriately answered by the Director of Medical Education or the staff member primarily responsible for educational programs. Please note that the Commission is solely concerned with continuing education of the medical staff and physicians of the community, not with house staff education, fellowships, or student training programs.

The Ohio State Medical Association Commission on Medical Education is eager to see educational programs initiated in community hospitals and is ready to provide assistance and consultation in the development of such programs.

John G. Sholl, M.D., Chairman
Commission on Medical Education

1. **Effective education committee for the attending staff:**
   Is continuing education for the attending staff a specific responsibility of a committee of the medical staff?
   YES _____ NO _____
   What is the name of the Committee?
   _____

2. **What are the charges to that committee and what are its goals?**
   (It is assumed that a major charge to the committee is to seek the improvement of patient care through continuing medical education and the evaluation of this procedure.)
   _____
   _____
   _____
   _____

3. If the committee has **other** responsibilities, what percentage of its time is devoted to continuing medical education for the attending staff?
   _____
   _____
   _____

4. List the members of the committee, their medical specialities and other hospital staff commitments, appointments, and their attendance in the past two years as a fraction (meetings attended to meetings held during period of membership).

(Chairman)

5. How many times did the committee meet last year? Are minutes kept?

6. How does the education committee plan to improve the quality of medical care through education of the attending staff? (Please give example. Do **not** append lists of courses nor C. V.'s of faculties.)

7. Please describe the relationships of your education committee to your hospital staff's executive committee, audit and review committees, hospital administration and governing body. Spell out the responsibility of each entity to continuing medical education.

8. Which committees or departments of the hospital are **not** represented on your education committee?

9. Is there an individual formally responsible for Continuing Medical Education?

YES _____ NO _____

10. What is his name, training (degrees) and title (e.g. Chairman of Continuing Medical Education Committee, Director of Medical Education)?

11. How long has he had this assignment? Is he full time? Part time? If part time, what percentage of his time is devoted to activities directly connected with Continuing Medical Education of the attending staff?

12. What is his term of office?

13. Does he have any staff at his disposal?

YES _____ NO _____

(If answer is "NO," skip to question 16)
If answer is "Yes," how many? _____

14. What are their responsibilities? (Please state what percentage of their time is devoted to continuing medical education.)

15. What are their qualifications?

16. Is there anyone available as resource in educational methods as opposed to content (e.g. curriculum development, evaluation etc.)?

YES _____ NO _____

If answer is yes, who, where from, qualifications and how used.

17. What educational opportunities has the Director of Continuing Medical Education (or Chairman of the Continuing Medical Education Committee) had in **educational methods** in the past five years?

18. How do you determine the needs of your attending staff for continuing medical education towards improvement of patient care? (Please state whether determination of education needs is made on a hospital wide basis or on departmental lines.)

19. What educational topics in your hospital have been developed in the past year as a result of patient care review procedures? (List at least three (3) and describe.)

20. Is there a plan for interdisciplinary in-service training of health personnel, i.e., the patient care team (perhaps on the model of training for ICU staff), and is there an education program for other professions in your institution? If yes, how does it relate to the physician education program?

21. Are Library Reference Services in your institution adequate for present demand?

YES _____ NO _____

22. Approximately how many volumes has your hospital medical library?

_____

23. To how many periodicals does the library subscribe?

_____

24. Does the library have the current Index Medicus?

YES _____ NO _____

25. Is there a salaried librarian?

YES _____ NO _____

26. What are the librarian's qualifications?

_____

27. Does your medical library have interlibrary loan arrangement with a larger medical library?

YES _____ NO _____

28. What is the annual budget for your hospital medical library?

_____

a) for personnel _____

b) for books _____

c) for periodicals _____

29. Is there currently in the library a "core library?"

YES _____ NO _____

30. Please append a copy of the institution's educational plan for the coming year. Do not include lists of activities nor C. V.'s of faculty.

31. Do guest speakers come primarily to give lectures or do they conduct live clinics and workshop-type activities?

_____

32. Are they used for other educational purposes, e.g., to help plan or as consultants or to review procedures, etc.?

_____

_____

_____

_____

33. What space is available for continuing medical education?

a) Ward and clinical conference rooms (include approximate number and student capacity of rooms) _____

b) Classroom and meeting rooms with flexible seating arrangements (approximate number) _____

_____

c) classroom and auditoria with fixed seating (approximate number) _____

d) Other (please specify) _____

34. What teaching aids are utilized in your program?

_____

_____

_____

_____

_____

35. Are sessions attended by non-staff members? If not, why not? What is being done to make these educational opportunities available to non-staff?

36. How many are there on your staff?
Full time _____ Active _____ Courtesy _____

37. Are attendance records kept?

YES _____ NO _____

38. Does your institution use a patient data summary such as Medical Advances Institute or similar services? Is there a plan for automation of patient data? If yes, is it used as an educational tool?

39. How do you find out whether educational activities have improved patient care at your hospital? Describe in detail.

(Use additional pages if necessary)

40. Are the teaching resources of a medical school used by the hospital?

YES _____ NO _____

41. If yes, in what manner (please describe).

42. Is there involvement of the hospital with the Regional Medical Programs in the area? Please describe

43. In addition to the above, please list other hospitals or other educational centers (such as Veterans' Administration, Public Health Service, mental health clinics, specialized hospitals, and rehabilitation center, etc.) used in conjunction with your continuing medical education activities. What is the kind and extent of your collaboration with them?

44. How is your local county medical society involved in your educational activities?

45. Are you currently engaged in a joint educational program with other hospitals in your area? (If so, please describe.)

46. Would your staff be willing to pool your resources with those of other hospitals in a combined educational program?

YES ____ NO ____

47. What is the nature of the commitment of your medical staff to continuing medical education?

48. What is the nature of the commitment of your governing body to continuing medical education?

49. What is the nature of the commitment of your administration to continuing medical education?

50. Has your institution been approved by other or previous Survey Programs within the past three years?

DOCUMENTATION

The following information will help the committee in considering the continuing medical education activities of your organization:

a) A statement of the precise objective of your educational committee.
b) A copy of the hospital's educational plan, the over-all program of the institution, and plans for the future.
c) A copy of your Medical Staff's statement of commitment to your program of continuing medical education.
d) Schedule of current year's activities in continuing medical education.
e) Copy of the organization chart showing continuing medical education unit.
f) Copy of the form for annual renewal of staff membership.
g) List of continuing education activities of last year.

(Use additional pages if necessary)

GUIDE FOR CONTINUING MEDICAL EDUCATION PROGRAM ACCREDITATION SURVEY TEAM

(Information to be obtained and evaluated during visit.)

1. Nature of Institution:
   a. Other types of programs offered
   b. Relation of continuing medical education program to overall program
2. Objectives:
   a. Immediate
   b. Long range
3. Administration:
   a. Departmental structure and its relation to the institution
   b. Full or part-time director
   c. Size of staff
   d. Planning and supervision of program
4. Budget:
   a. Size, adequacy
   b. Paid faculty
   c. Size of fees
5. Faculty:
   a. Number
   b. Staff physicians
      1) Relation to medical school faculty
      2) Experience in medical education
      3) Other responsibilities and special qualifications
   c. "Home grown" or imported
   d. Responsibility of faculty for quality of program
6. Curriculum:
   a. Consistency with objectives
   b. Variety of courses and degree of coverage of special fields
   c. Scope and intellectual level of courses
   d. Value to physician
   e. Manner of selection and design of courses
7. Size and Scope of Program:
   a. Number of continuing medical education activities per year
   b. Number of hours per year
   c. Number of enrollments per year
   d. Number of separate physicians enrolled per year.
   e. Number of regular repeaters
   f. Area of influence
      1) Number of states from which enrollees come
      2) Proportion of state or regional physicians
8. Facilities:
   a. Location of activities
   b. Rooms provided—size, suitability
   c. Teaching aids and media
   d. Availability of hospital or clinic for patient teaching
   e. Availability of room and board for enrollees
9. Educational Methods:
   a. How are educational needs determined?
   b. Variety of teaching methods-% of each
   c. Degree to which participation-type methods are used. Are they adequate?
10. Evaluation:
    a. Methods of evaluation used, e.g. examinations, etc.
    b. Enrollee reactions
    c. Faculty reactions
    d. Mechanism for revision of courses on basis of evaluation
    e. Effect on patient care in area served
11. Reward:
    a. Certificate or diploma given
    b. AAFP credit
    c. ACGP/OMS credits
    d. Records for verification
12. Summary:
    a. General quality of overall program
    b. Recommendation for approval or disapproval

TEAM REPORT INSTRUCTIONS

(Procedure for surveys of continuing medical education programs)

Introduction: Site visit team members are reminded that they are at the institution by invitation. It is emphasized that this is to be a cooperative and consultative relationship, and in no sense an "inspection." Instead, it is intended that a learning environment will be achieved.

1. Team members will meet prior to the site visit, either by telephone conference or immediately on arriving at the site. They will compare impressions of the questionnaire and develop a plan.

2. The schedule for the visit should be developed by the local director along lines discussed with chairman of team.

3. At any time the chairman of the team decides to do so, the team will pause for a recess to review program, examine charts, minutes, or other documents. Review of a C.M.E. activity is required at the time of the team visit.

4. A tour of the hospital will provide an opportunity for conversations with members of the attending staff not directly participating in the continuing medical education program, also with nurses, patients, and other allied health personnel.

5. The survey team will assess the effectiveness of some specific recent educational activities.

6. Reports will be organized as the questionnaire is organized. They will be sufficiently complete for the Commission to judge whether the standards are met. The team member is required to provide data objectively.

7. One of the following recommendations must be made to the Commission on Medical Education for each of the programs on which there is a report by a survey team:

A. Accreditation of the institution or agency for a maximum of 4 years.

B. Accreditation of the institution or agency contingent upon stipulated changes in the program. (This classification would apply in those cases where the program does not meet the requirements for accreditation but seems to have the potential for doing so.) Accreditation would be granted only when contingency is met and would be for a limited time only. A resurvey should be made within a stated period of one or two years.

C. Provisional accreditation of the institution or agency. (Applicable only in newly developing programs, and with a time limit of one or two years.)

D. Nonaccreditation of the institution or agency. (In such cases, the Commission is to be provided with reasons for the recommendations.)

OHIO STATE MEDICAL ASSOCIATION
Commission on Medical Education

Continuing Ed. Network Accepting Hospitals For 1975 Programs

Openings still exist for hospitals wishing to join the Ohio Medical Education Network and receive its weekly noon-hour closed-circuit programs of continuing medical education. The twelve programs in the network's January-April 1975 season will include discussions about Stroke, Epilepsy, High Risk Pregnancies, Drug Use, and Breast Cancer.

The programs feature a lecture, accompanied by slides, plus an opportunity for physicians at participating hospitals to phone in questions to the lecturers. The physician-panelists are drawn from the medical faculties of The Ohio State University, Case Western Reserve University, The University of Cincinnati, and The Medical College at Toledo.

Dr. Robert B. Schweikart, Director of the Center for Continuing Medical Education at Ohio State University, serves as moderator for the two way dialogue. The one hour programs are carried out with the assurance of professional privacy and are acceptable for Continuation Study Credit by the American Medical Association and the American Academy of Family Physicians.

The cost varies from $13 to $20 per program, depending upon hospital size. Additional costs include charges by the hospital's local telephone company for the installation of telephones plus the cost of telephone calls made to Columbus to receive the program and question the panelists.

At present, the network has five openings available on Wednesday, four on Thursday, and one each on Monday and Tuesday. Space for interested hospitals is available on a first-come first-serve basis. Hospital administrators should act promptly as it takes at least four weeks to handle the administrative details required to assure early January, 1975 reception of the programs. For further details, contact Dr. Schweikart or Arthur Bartfay at:

The Center for Continuing Medical Education
The Ohio State University
College of Medicine
320 West Tenth Avenue
Columbus, Ohio 43210
(614) 422-4985

P. John Robechek, M.D., of Cleveland, a Past President of the Ohio State Medical Association and a member of the Ohio Delegation to the American Medical Association House of Delegates, has been elected to a three-year governor-at-large term on the Board of Governors of the American College of Surgeons.

Other Ohio physicians serving on the Board of Governors are Miles Flickinger, M.D., Lima; Zeph J. R. Hellenbeck, M.D., Columbus, and Thomas W. Morgan, M.D., of Gallipolis (for Ohio), and specialty representatives James E. Bennett, M.D., Cleveland; E. Thomas Boles, M.D., Columbus, and George E. Spencer, M.D., Cleveland.

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TOLEDO: Suite 221, 5241 Southwyck Blvd., (419) 865-5215, R. E. Stallter

The Impact of a Computerized Peer Review System On Continuing Medical Education

Robert R. Clark, M.D. - President
Medical Advances Institute

Medical Advances Institute, at the direction of the OSMA Council and the House of Delegates, has developed a highly sophisticated, computer assisted system for peer review. The purpose was not only to comply with the Federal law, P.L. 92-603, but to establish a system that achieved the AMA's determination "to create an unassailable peer review system for *all* hospital patients."

While accomplishing this goal, MAI has managed to produce an instrument that can be used for many other purposes. Perhaps the most striking and important of these spinoffs is the tremendous impact it will have on continuing medical education. Many do not appreciate the significance of structuring a data collection and bookkeeping instrument such as the peer review computer mechanism has achieved. It is the intent of this article to alert Ohio physicians to the vast implications of such a data base on continuing medical education.

The MAI Peer Review System

The MAI system, when in full implementation, provides a screening mechanism for peer review for every hospital staff in the state of Ohio. When a patient is admitted to the hospital, a nurse coordinator generates information to the computer as to the reason for the patient's admission, demographic information, diagnoses both primary and secondary, and services rendered to the patient. This is accomplished within the first 24 hours of admission, and then an ongoing review of services rendered, complications, therapy, etc. continues throughout the patient's stay in the hospital. A summary review of these activities at discharge completes the information transmitted to the computer.

All of these steps are necessary to allow a review by a peer physician in each hospital to determine the quality of care that has been provided. Those items on the patient's chart which do not fall within the disease specific parameters predetermined by the specialty panels of MAI will be reviewed by a physician selected by the local hospital committees.

These exception reports will be analyzed by local practicing physicians to determine whether or not they are significant. Analyses of these exception reports, and what action was taken on those that were significant, will be passed on to the Local and Regional Peer Review Councils to assure that review teams are doing a proper job and thus producing public accountability.

The above is, in a nutshell, a summary of how the peer review system works. Anyone desiring more detailed information on the mechanics of using the computer screen and review by local peers is invited to peruse the myriad of publica-

tions by MAI and the Ohio State Medical Association on this subject.

The purpose of this paper, however, is to analyze the impact of this system, not on peer review, but on continuing medical education. It should be evident that in carrying out such a peer review system, the computer has compiled a fantastic amount of information which can be useful for other purposes. We have therefore programmed the MAI system very carefully to allow the extraction of this information for the purposes of allowing analysis of data and producing statistical bases for continuing medical education.

The Individual Physician

The first consideration in continuing medical education is the improvement of the knowledge and techniques of the individual practicing physician. This takes place in the reading he does, the meetings he attends, and the programs that are provided. One of the major difficulties in this process is the lack of selectivity of the material to which he directs his attention for improving his standard of practice.

At the present time, there is no methodology which allows the individual physician, despite his earnest intent, to know to which areas he should direct his efforts. Chairmen of continuing education committees notoriously select topics in fields which by their nature are popular and will produce a maximum attendance at the meetings. This may make the continuing education committee chairman appear to be a good one, but it does not necessarily provide the staff members information in those particular fields in which they are weakest.

The accumulation of data in the computer and our programming allows us to develop physician profiles. These, when made available to the individual physician, allow him to compare his outcomes, his use of services, his admitting practices, and his accuracy of admitting diagnoses against those of his peers.

By this mechanism alone, the pride of physicians will direct them to enhance their continuing medical education in the areas most needed. They also will have a chance to see by the statistics generated what type of improvement they are able to make through educational efforts. It is my opinion that this will be a tremendous asset to individual physicians to be able to pinpoint their deficiencies so they may take proper action to correct same.

Evaluation of Individual Performance By Peers

The above discussed statistics of utilization of services, outcome results, etc. provides another continuing educational experience: the ability of the staff to have some method of accurately defining individual performance. This allows divisions and departments within a hospital staff to suggest improvement to a deficient staff member not from a biased and personal attitude, but rather on a statistical basis, revealing his deviation from parameters established by the physicians of the state of Ohio.

While all of the physicians did not establish the parameters, the specialty panels were composed of a well-selected, random sampling of physicians in that specialty and usually selected by the state specialty society. Since the criteria are being applied to all others in that specialty, such deviations, while not necessarily onerous, certainly require explanation. This, for the first time, gives the departments and divisions of the staff a lever to require proper and good quality medical care from the staff members.

Divisions and Departments of a Hospital Staff

Not only do these statistics allow the analysis of the need for continuing medical education of individuals in a department or division, but also their generation allows a division or department to compare itself with similar staffs in other hospitals. The orthopaedic staff at Akron City Hospital can now compare utilization of services and its length of stay with Riverside Hospital in Columbus. If a notable discrepancy arises, it is now able to investigate and gain insight into the reasons for the differences of practice in the two institutions.

Since the computer has all the data necessary to analyze these various ramifications, department meetings will change in their nature to discussions directed at this aspect of mass continuing medical education. Dissemination of information on procedure and necessity for services can be undertaken. Never before has this type of information been available to hospital staff departments, and the utilization of this type of report, which can

easily be generated from the data base of the computer, will be a tremendous stride in continuing medical education.

Hospital Staff as a Whole

The information compiled on the computer on a statewide basis allows individual hospitals and their staffs to compare themselves to similar hospitals across the state. This allows the medical staff to evaluate its performance, not only in individual disease entities but in general relationships, to outcome produced by the care rendered in similar institutions outside their locality. While these overviews will undoubtedly be referred to divisions and departments for action, it certainly allows the staff as a whole to weigh its performance in the deliverance of medical care in the state of Ohio.

Standing Committees of Hospital Staff

The standing committees of most hospital staffs, such as Utilization Review Committee, Medical Standards Committee, Tissue Committee, etc, will be relieved of the mundane efforts of leafing through charts and playing inefficient games, the committee can now concentrate on the meaningful aspects of analyzing the data produced. The computer program makes this possible, enabling these committees to request the type of information that makes their analysis meaningful. The data enables the committee to take a good hard look at the frequency and timeliness of texts and x-rays that are ordered, as well as the efficacy of the diagnoses and the success of the outcome. Decisions for improvement on quality medical care can then be generated on a statistical basis.

Administration

Continuing medical education in its broad sense is not limited in any way to the medical staff or the practicing physicians. Data contained in the computer will allow, for example, Administration to analyze a variety of entities. The cost estimates per admission for a specific diagnosis will not only be available, but projection of these costs to the near future can be generated by extrapolation by the computer. Costs can likewise be analyzed in comparison to other hospitals of similar size and activity.

The data will also be able to give an administrator some indication of seasonal trends of various disease entities and allow adequate planning on bed allocation. Experience will indicate other areas which can have meaningful data extruded from the data base which will help reduce total cost.

Nursing Service

Continuing medical education does not exclude the nursing profession. The nursing service will be able to generate from the data, indications of the effectiveness of the services provided and indications for improvement. A very meaningful comparison between those hospitals which utilize nurses to perform a very sophisticated type of service and those hospitals which still require M.D.'s to perform these services will be very interesting. Indications for improved relationships and provision of these ancillary services by the nursing department in the hospital will come into an entirely new type of scrutiny with the statistics generated by this type of system.

Government and the Public

Continuing medical education is not exclusive to the medical profession and the ancillary services providing medical care. In our society today, a great impetus in the course of provision of medical care is provided by the government and the public in general. This system will provide data for the first time that is totally accurate in analyzing the existence of problem areas. This will provide a statistical basis on which the government can take further legislative actions to properly involve itself in correction of existing problems in deliverance of medical care. Conversely, the system will illustrate those areas where a mere mirage has been formed by inaccurate data. Meddlesome legislation to correct such nonexistent problems will no longer be valid or considered.

In addition, the system will provide data in the form of cost analysis, allowing the American public to intelligently make judgments as to what they want and what they can afford in the form of deliverance of medical care. It also will document the excellence of care now being provided by the American medical system.

Formal Education

An analysis of continuing medical education aspects would be incomplete without some anticipation of what effect this will have upon the medical school curricula, and the philosophy under which it is taught. At present, the medical student who can come up with the longest differential

diagnosis and the longest order sheet to rule out these diagnoses is considered the most erudite. However, in theory, the most efficient medical practitioner is he who could order one lab test to prove a patient has a given disease and then carry out its management.

Somewhere between these two extremes lies good medical practice. The development of this type of criteria of good care most nearly approaches that ideal interim which is good quality and still economically feasible. I would contend that the existence of such a system would change the medical student's philosophy toward a more efficient use of the medical facilities available when directing his attention to diagnosis and treatment of an individual patient.

In addition, this type of system allows an ongoing analysis of the performance of a student or resident. It precludes the sit-down, pressure-laden written examination, allowing the analysis of his performance on a day-to-day basis. This same basic philosophy eliminates the necessity for recertification of practicing physicians and should be considered very strongly in lieu of recertification examinations and/or any other type of in-practice examinations.

It is a situation in which one running a training program or medical school no longer has to wait for the annual in-training examination or the periodic examinations in a medical school curriculum to evaluate the individual's performance. The educational deficiencies of the student become apparent on an ongoing basis and can be corrected when it is timely and productive.

Curriculum Committees

The evaluation of performance of recent graduates should be of utmost significance to the curriculum committees of the individual medical schools. Only by such statistical analysis as is available from this data base can these curriculum committees have any valid basis on which to alter their curricula and their training mechanisms for future improvement. It would be obvious that deficiencies demonstrated by such data on their recent graduates would indicate deficiencies in their training program, and changes in the curricula to improve these areas of lack of adequate instruction could be undertaken.

In other words, a medical school finding their graduates of recent vintage are performing poorly in internal medicine, as compared to the graduates of other schools doing internship and residency in the state of Ohio, would have basis to upgrade that segment of the undergraduate education. This statistical information can very readily be generated from the information contained in the computer doing peer review analysis.

Epidemiology

It is readily apparent that information contained in this type of data bank produces epidemiological studies never before available. This is a type of continuing medical education. There are statistics for at least one hundred PhD. papers contained in the information already collected by the MAI-PRS system on a mere model basis. The future possibilities boggles the mind as to what studies can be generated by very minor modifications of the program.

Clinical Research

The experience on the model programs shows that record keeping in the hospitals under review is vastly improved. Improved records alone produce more accurate clinical research. This is, in fact, a major contribution to continuing medical education. As analysis of records which are more adequately documented progresses, the conclusions arrived at from such analyses will be much more significant in the education of physicians reading these reports.

In addition, the computer with its bookkeeper role enhances greatly the ability of the researcher to extract information from the existing records. This, too, will allow a great expansion of research on patients and clinical entities, and will promulgate continuing medical education.

Conclusion

While the MAI-PRS system was devised to provide a concurrent and retrospective review of the quality of medical care of inpatients in the state of Ohio, it is evident that success in that field will be of a secondary importance. While this system may well provide some improvement in quality care by its mere existence, its greatest improvement in the delivery of medical care will be its positive impact on the multi-faceted field of continuing medical education.

Professional Activities



AMA House of Delegates — Clinical Convention 1974

December 1-4

Portland, Oregon

BUSINESS BEFORE THE HOUSE OF DELEGATES:

The AMA House of Delegate's Handbook (which arrived at OSMA Headquarters Nov. 11) contains 58 resolutions.

There are 54 Board of Trustees and Council Reports.

The OSMA has introduced 3 resolutions.

One member of the Ohio delegation has introduced a resolution with the concurrence of the OSMA Council.

There are 26 resolutions and reports on Federal Legislation.

YOUR OSMA Delegates Solicit Your Advice and Counsel On This Proposed Legislative Program.

Consulting Medical Editor Named For Ohio State Medical Journal

Dr. James Henry, OSMA President, has announced that Richard L. Meiling, M.D., Columbus, has accepted the position as Consulting Medical Editor of The Ohio State Medical Journal. A former President of the OSMA, Dr. Meiling has distinguished himself in many fields, including private practice, medical education and administration, military medicine, and medical professional organizations.

Dr. Meiling recently served as a consultant to medical faculties and government health programs in Australia, Thailand, Nepal, Iran, Egypt, Germany, and Greece, returning to Columbus late in October.



Dr. Richard L. Meiling

A member of one or more American Medical Association Councils since 1947, Dr. Meiling has also served in the AMA House of Delegates for over 20 years. In 1952, he served as Treasurer of the Ohio State Medical Association, becoming President in 1956. He has held several responsible positions in the Academy of Medicine of Columbus and Franklin County. He holds membership in several national and international medical organizations involving surgery, obstetrics and gynecology, and medical education.

Dr. Meiling, a native of Springfield, received his medical degree with honors from the University of Munich, Germany in 1937. Upon completing graduate work at Western Reserve University Hospital in 1947, Dr. Meiling came to the Ohio State University College of Medicine as an Assistant Professor in Obstetrics and Gynecology and as an Instructor in Pathology. At the same time, he established himself in the private practice of his specialty in Columbus.

In 1948, President Truman asked Dr. Meiling to serve as Medical Advisor on National Security in the first Hoover Commission. In 1949, he accepted the position of Assistant to the Secretary of Defense for Medical and Health Affairs, serving under Secretaries Forrestal, Johnson, Marshal, and Lovett.

In 1951, Dr. Meiling returned to the Ohio State campus as Associate Dean of the College of Medicine, Associate Director of University Hospitals, and Associate Professor of Obstetrics and Gynecology. Several years later, he assumed the added responsibilities of Professor of Preventive Medicine, and in 1967, of Professor in the School of Allied Medical Professions. On January 1, 1961, Dr. Meiling began his duties as Dean of the College of Medicine and Director of University Hospitals, continuing his professorships at the same time. He continued in this position until 1970 when he was appointed Vice President for Medical Affairs, the first to hold this position at Ohio State.

From October 1940 to January 1946, Dr. Meiling served on active duty in the U.S. Army. He retired with the rank of Major General in the U.S. Air Force Reserves in 1968.

Currently, Dr. Meiling is an Emeritus Vice President of Medical Affairs and Emeritus Professor of Obstetrics and Gynecology. He continues his private practice.



1975 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1975 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus, Ohio. Exhibit Days and Times will be as follows: Monday, May 12 — 12:00 Noon - 4:00 P.M.; Tuesday, May 13 — 9:00 A.M. - 4:00 P.M.; and Wednesday, May 14 — 9:00 A.M. - 3:00 P.M.

Mail applications to the attention of J. E. Tetirick, M.D., Chairman, Committee on Scientific Work, Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215.

APPLICATION FOR SPACE SCIENTIFIC EXHIBITS

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Veterans Memorial Building, Columbus, May 12, 13 and 14

___I am interested in receiving an application and details regarding space for a scientific exhibit at the 1975 OSMA Annual Meeting. Please send to:

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Executive Editor Retires After 26 Years



Gordon Moore, retired Executive Editor and Executive Business Manager of The Journal, and his wife, Betty, admire a gift from the staff of the OSMA Headquarters. The gift was presented during a party held recently in honor of Mr. Moore upon his retirement.

On October 19, the staff of the OSMA Headquarters gathered for a buffet and party in honor of Gordon Moore, who had retired a few days earlier as Executive Editor and Executive Business Manager of The Journal. Dave and Martha Rader hosted the party in their home.

During his 26 year career with the Association, Mr. Moore witnessed many changes in The Journal's size, scope, and circulation. Since 1938, The Journal's circulation has increased from less than 8,000 to approximately 11,000.

Tokens of appreciation from the staff and the Association were presented by Hart Page, OSMA Executive Director, who outlined the highlights of Mr. Moore's long and faithful service to the Association.

Attending the party with Mr. Moore were his wife, Betty, and daughter, Jane. Also present were Charles S. Nelson and George (Scottie) Saville, retired Executive Secretaries of the Association, and Miss Florence Okert and Mrs. Edna Latimer, retired staff members.

The staff wishes Mr. Moore well in his future plans, which include working with the Association as a Consultant for special projects.



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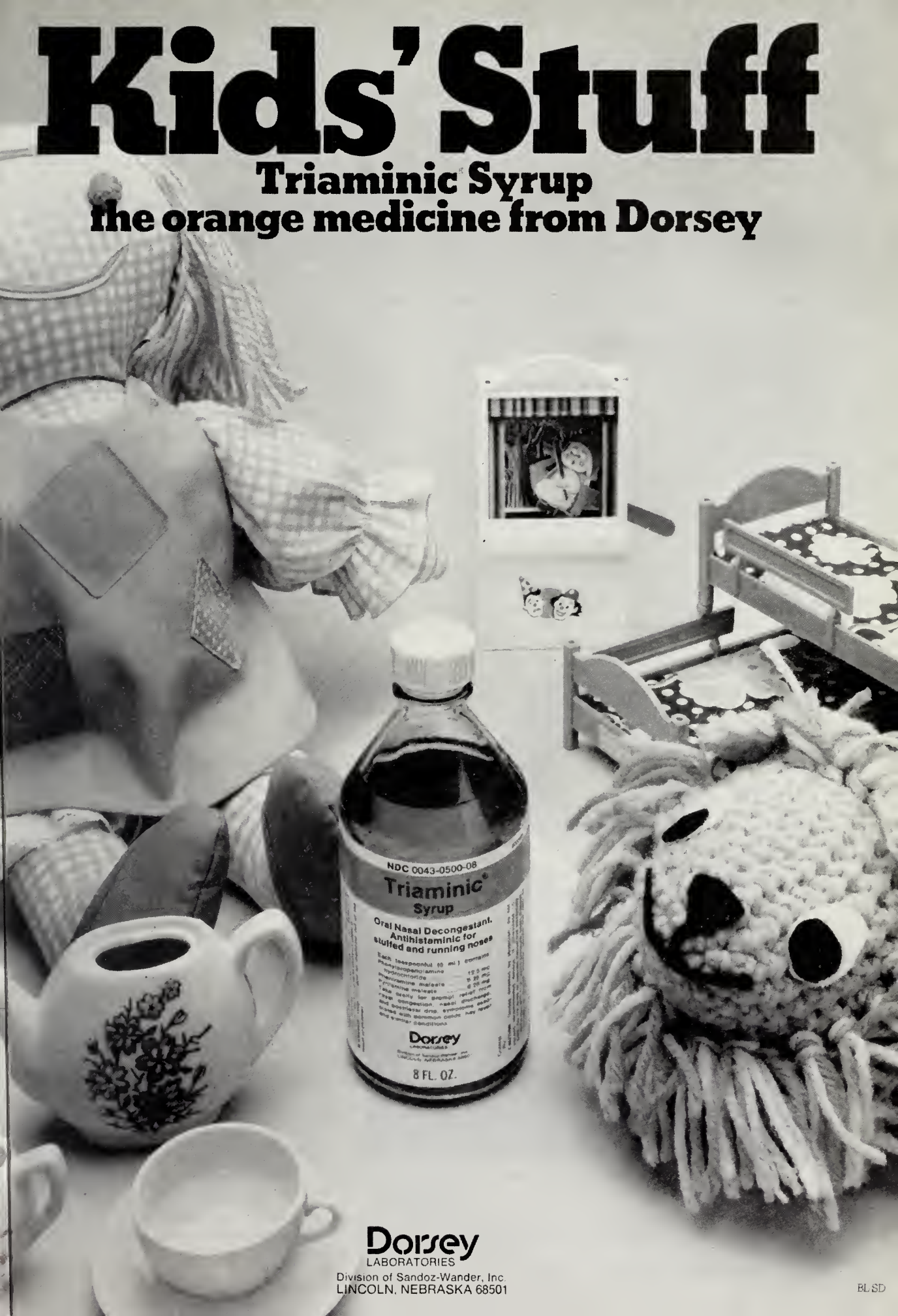
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Obituaries

Maynard J. Brucker, M.D., Amherst; Marquette University School of Medicine, 1951; age 49; died October 26; member of OSMA and AMA.

Samuel E. Burkhart, M.D., Cleveland; Hahnemann Medical College, Philadelphia, 1939; age 60; died October 24; member of OSMA and AMA.

Edward L. Burns, M.D., Toledo; Washington University School of Medicine, 1928; age 69; died October 10; member of OSMA and AMA.

Braxton Fancourt Cann, M.D., Cincinnati; Howard University College of Medicine, 1930; age 73; died October 29; member of OSMA.

James Newton Christiansen, M.D., Cincinnati; Loma Linda University School of Medicine, 1929; age 73; died October 21; member of OSMA and AMA.

Frederick Stanley Coombs, Jr., M.D., Youngstown; Western Reserve University School of Medicine, 1933; aged 67; died October 6; member of OSMA and AMA.

Herbert Augustus Davidson, M.D., Barberton; Howard University College of Medicine, 1932; age 74; died October 3; member of OSMA and AMA.

Allan Harvey Driels, M.D., Cleveland; University of Breslau, Germany, 1922; age 80; died July 17; member of OSMA and AMA.

Robert Ambrose Evans, M.D., Columbus; Georgetown University School of Medicine, 1938; age 68; died October 7; former member of OSMA and AMA.

Joseph Henry Goldcamp, M.D., Cincinnati; University of Louisville School of Medicine, 1941; age 64; died October 6; member of OSMA.

Lyle Williams Kahler, M.D., Toledo; Wayne State University School of Medicine, 1947; aged 60; died October 12; member of OSMA and AMA.

Arthur Deane Lewis, M.D., Jeromesville; Ohio State University College of Medicine, 1933; age 79; died October 22; member of OSMA and AMA.

Robert Ecklund Lynner, M.D., Akron; University of Minnesota Medical School; 1954; age 45; died October 15; member of OSMA.

Jacob Allen Ziskind, M.D., Columbus; Ohio State University College of Medicine, 1923; age 75; died October 3; member of OSMA and AMA.

The following publications can be obtained from the American Foundation for the Blind:

F208 *Facts About Blindness.* 16 pages. 50 copies free. 51-200 copies, 8¢ each. 201-500 copies, 7¢ each. 501-1000 copies, 6¢ each. Revised and redesigned pamphlet giving basic facts about blindness and services for the blind.

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Wright State Med School Gains Two Dept. Chairmen

Wright State University, Dayton, has announced two major appointments for the new School of Medicine. Douglas P. Longenecker, M.D., Dayton, has been recommended as associate professor and chairman of the Department of Family Practice. Emmanuel Kauder, M.D., Middletown, has been named professor and chairman of the Department of Pediatrics.

A native of Dayton, Dr. Longenecker interned at Good Samaritan Hospital. Following seven years of private practice in Englewood, he helped organize and served as director of a new family practice program at Good Samaritan during 1972-73. Since that time he has been director of family practice at Riverside Methodist Hospital, Columbus.

He is certified as a charter diplomate of the American Board of Family Practice, and as a charter fellow of the American Academy of Family Physicians. Among committee memberships are the Ohio Academy of Family Practice undergraduate and graduate medical education committee.

A native of Brooklyn, N.Y., Dr. Kauder received his M.D. from New York University College of Medicine. He has been associated with the University of Cincinnati Department of Pediatrics since 1958.

Dr. Kauder holds board certification from the American Board of Pediatrics and is a member of the American Society of Hematology and the Society for Pediatric Research. He has served as consultant to major Dayton area hospitals and is author of numerous papers in the fields of general pediatrics, pediatric hematology and oncology.

Both appointments are contingent upon approval by the Wright State University Board of Trustees.

A U.S. Public Health Service award of $474,381 has been granted for continued support of the Acute Spinal Cord Injury Research Center at Ohio State University. Directed by Dr. William E. Hunt, department of surgery, the center is attempting to identify and minimize secondary destructive changes occurring soon after injuries in which the spinal cord is damaged but not severed. The center's research, involving seven departments in three colleges, is aimed at developing methods of early identification and treatment of such injuries.

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Woman's Auxiliary Highlights

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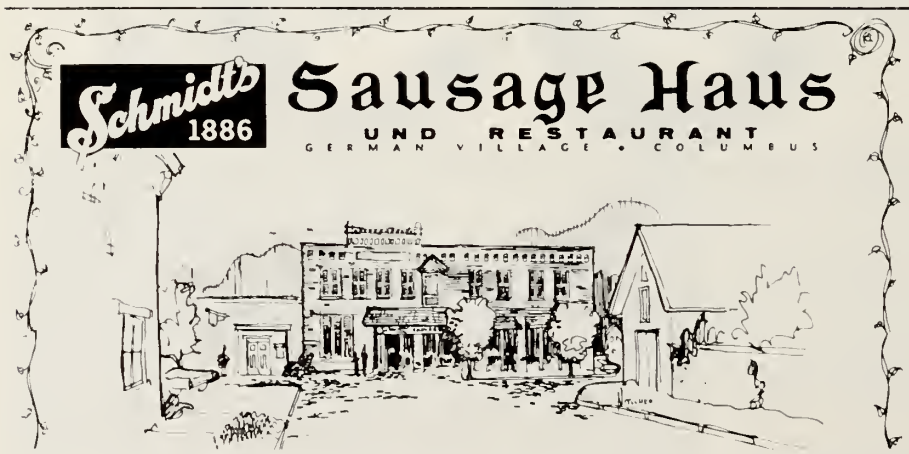
Hanging an Item or Two or Three On the Auxiliary's Christmas Tree . . .

AUXILIARY'S CHRISTMAS TREE? Even if such a tree is hardly in the realm of reality, you have to admit that it's no less imaginative than Santa Claus himself. And no less significant. For our tree, like the myth of Santa Claus, symbolizes a special something. And what I choose to call the "ornaments" to be hung bright and shiny on it are the dedicated and sparkling activities of our county auxiliaries. And fittingly, that's what this December column should be, and is, all about. (Unfortunately, though, our "tree" doesn't have enough space to carry every deserving ornament!)

From **Butler County:** Child Transportation Safety is being stressed this auxiliary year with the placement of pertinent literature in the OB and Pediatric departments of all the hospitals. The literature stresses child safety and lists the approved car seats. The lawn mower safety slide program continues to be available to all interested community groups. The October 22 morning "Coffee" featured Elizabeth Duncan, an authority on children's literature. She discussed "Children's Literature Updated," a definitely provocative subject considering the changes that have occurred.

From **Cuyahoga County:** The October 24 luncheon meeting at the Mid-Day Club (at which tribute was paid new members and past presidents) was honored with the presence of Dr. Donald Effler, head of the department of Thoracic and Cardio-Vascular Surgery at Cleveland Clinic. He spoke on "A Surgeon's Impression of Red China Today." Mrs. John Liambeis, Cuyahoga president, and Mrs. Daniel Maras, community service chairman, recently visited the Alcoholic Treatment Center at Woodruff Hospital to make a tour of the facilities and to look over the three rooms furnished through the auxiliary's $900 contribution for that purpose. "The Right Side (of the Caduceus)" is the name of an informative, interesting and new monthly column in "The Cleveland Physician," written by Mrs. Christopher Colombi, a past state president. Glad to have you aboard, Vi!

(Continued on page 762)

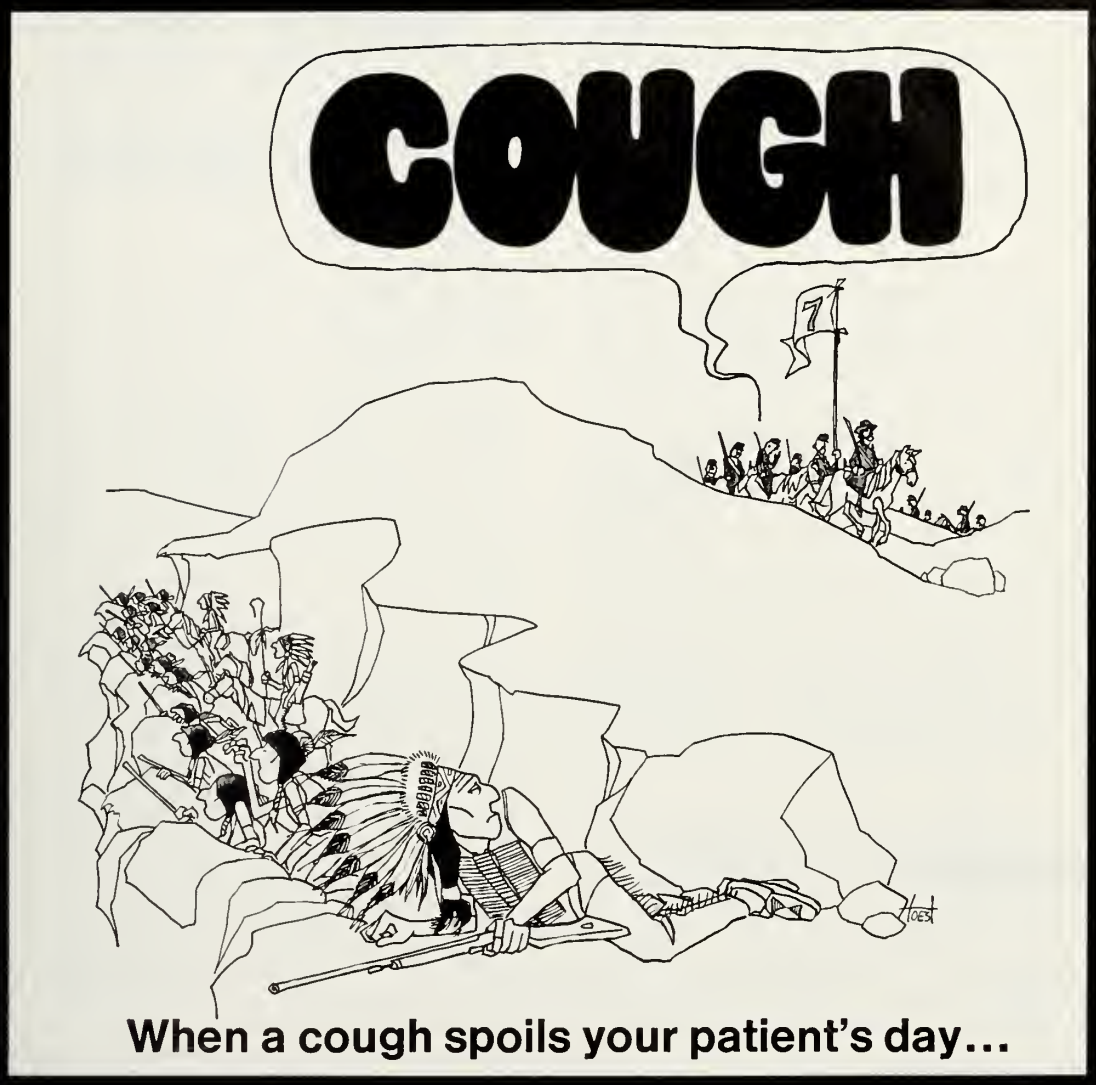


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(continued)

From **Hamilton County:** The quick response and enthusiasm shown by fifteen auxiliary members who answered a request by the Epilepsy Foundation for volunteers for their October School Alert program indicate yet again the tremendous role played by doctors' wives in the volunteer program. These particular fifteen attended a two-hour training session at the new College of Medicine. One of their jobs was to hand-deliver kits containing material on epilepsy to area school nurses, and that covered a lot of territory! The auxiliary's October 22 luncheon meeting, the first of the new season, took place at the Cincinnati Playhouse. There were guided tours of the backstage area of the theatre and an informal talk by Ron Stall, director of audience development and house manager.

From **Jefferson County:** The Downtown Business Association in Steubenville again sponsored a Fair in October at which the auxiliary distributed pamphlets and literature from the Governor's Committee on Aid to the Handicapped and from the Jefferson County Vocational Rehabilitation Agency. The goal was to educate the public to the needs and abilities of handicapped persons. Mrs. William Myers, state first vice-president and membership chairman, visited Jefferson County a couple of months ago to talk on Membership as the "big M" in Medical Auxiliary. She pointed out that membership equals manpower, money, motivation and mobilization, all necessary for a strong medical auxiliary. About $135 was raised for the group's general fund by a Garage Sale held early in October. The month's meeting featured as its guest speaker Judge John Spon who discussed the community's social problems, with special emphasis on juvenile delinquency and child abuse.

From **Lucas County:** The drug collection takes a new twist this year. The auxiliary will donate the drugs to community clinics if an adequate supply is collected. What cannot be used in Toledo will be sent to Detroit and the World Medical Relief. The medical, dental, and bar association auxiliaries co-sponsored a meeting and dessert on November 12 at the Academy of Medicine building. The program was on Child Abuse; the speaker, Dr. Susan Scheurer. The Fourth District Luncheon and Meeting was held at the Toledo Club under the chairmanship of Jean Youngen. The Lucas auxiliary was hostess to Ottawa and Sandusky counties. *Seventeen* study group sessions have been set up for the 1974-75 year. Lucas does an incredible job with these study groups. More on that next month.

From **Mahoning County:** Mrs. Robert L. Gilliland, president, and her board have really been setting a fast pace ever since late summer, beginning with a buffet supper for the new board members and their husbands. This was soon followed by an orientation session for area physicians' wives who had recently become members of the auxiliary. And then the new board presented its 1974-75 program which will include: a special program on "The Family in America Today" with emphasis on the adolescent years; the AMA-ERF Fashion Show for the benefit of Youngstown State University Medical School Division; a community health symposium on child abuse; the compiling of a health careers brochure outlining areas of needed health manpower and available financial assistance; a special project for the aged; the annual drug collection for World Medical Relief; a program on family relations in the area of medical marriages to which members of the Trumbull County auxiliary will be invited.

This is the most beautiful and significant Season of the Year. May your Holidays be joyous. Merry Christmas!

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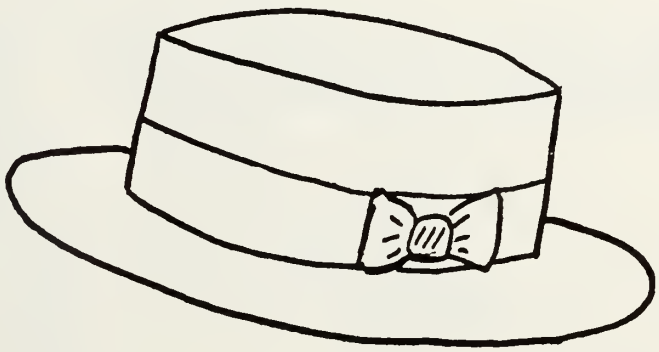
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A copy of our report, filed with the appropriate supervisory officer is (or will be) available for purchase from the Superintendent of Documents, United States Government Printing Office, Washington, D. C. 20402.

Ohio State To Review Criteria For Admitting Students

President Harold L. Enarson of Ohio State University was authorized to appoint a task force to review criteria for admitting students to the university's professional graduate colleges.

The university's Board of Trustees in October endorsed a recommendation of its Educational Affairs Committee requesting the study.

The task force to be named will have representation from each of Ohio State's professional graduate colleges of Dentistry, Law, Medicine, Optometry, and Veterinary Medicine.

Dr. B. Leslie Huffman, Jr., of Maumee, was elected speaker of the Congress of Delegates of the American Academy of Family Physicians. The AAFP is the nation's largest national medical group, having more than 36,000 members.

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THE OHIO STATE MEDICAL JOURNAL

INDEX TO VOLUME 70—1974

January	Pages	1	to	68	July	Pages	399 to 482
February	"	69	to	140	August	"	483 to 534
March	"	141	to	204	September	"	535 to 592
April	"	205	to	288	October	"	593 to 642
May	"	289	to	346	November	"	643 to 706
June	"	347	to	398	December	"	707 to 772

CLINICAL AND SCIENTIFIC PAPERS

Abortion and Red Rubber Catheters. A Case Report and Discussion (Amrutha Bhakthavathsalan and Melvern A. Ayers) 108

Acoustic Neuromas (See Early Diagnosis of)

Active Tuberculosis (See Sensitivity of Intermediate)

Agenesis of Gallbladder. Case Report and Discussion (Henry W. Brown; Elias M. Nicolas; and Madhira D. Ram) 630

Allergic Bronchopulmonary Aspergillosis. An Unusual Clinical Presentation (Michael S. Kreindler and James I. Tennenbaum) 421

Angiography (See Pulmonary)

A New Look at the Larynx (Harold C. Klein) 31

Appendix, Intussuscepted (See Cecal Mass)

Arthroplasty of Rheumatoid Knee (See Evaluation of McKeever Tibial Plateau)

Aspergillosis (See Allergic Bronchopulmonary)

Awareness of Sickle Cell Abnormalities. A Medical and Lay Community Problem (William I. Young; Joseph Peters; Harold B. Houser; and Eddie B. Jackson, Jr.) 27

Erratum to above article 179

Bongo Drum Hematuria (Hassan Mehbod) 169

Breast Necrosis (See Coumarin-Related)

Bronchogenic Carcinoma (See Pulmonary Angiography)

Cancer (See Intestinal Cancer)

Carcinoma (See Squamous Cell)

Carcinoma of the Breast (See Treatment of Operable)

Cecal Mass Due to Intussuscepted Appendix. A Plea for Conservative Therapy. (Ivan L. Shapiro and H. Treat Cafferata) 671

Cervical Carcinoma In Situ at Akron General Hospital Medical Center: The Value of Colposcopy (William T. Yates and William A. Cook) 625

Clinical Value of Lecithin and Sphingomyelin. Determinations in Amniotic Fluid (E. Damoulaki-Sfakianaki; C. DeWalt; C. R. Macpherson; and L. Cordero) 35

Colposcopy (See Cervical Carcinoma in Situ)

Community and the Institution, The (Gerhard E. Martin) 98

Conjunctiva (See Squamous Cell Carcinoma of)

Coumarin-Related Breast Necrosis. A Case Report and Review of the Literature (Emmerich von Haam; John F. Seidenstricker; and Glenn E. Hatfield) 38

Cryptococcosis of Bone. Case Report (Miguel A. Pedraza) 559

Cystadenocarcinoma (See Papillary)

Diagnostic Peritoneal Lavage in Acute Abdominal Problems (William R. Schiller and John H. La Voo) 313

Early Diagnosis and Management of Acoustic Neuromas (John M. Tew, Jr.; Richard J. Wiet; and Frank H. Mayfield) ... 365

Edema (See Nontoxic)

Encephalopathy (See Lead)

E.N.T. Case of the Month (Andrew W. Miglets, Jr.) .. 37, 101, 171

Epiphysis (See Slipped Femoral)

Erratum 179

Evaluation of McKeever Tibial Plateau Arthroplasty of the Rheumatoid Knee (Richard A. Freiberg and Paul W. Welch) ... 316

Femoral Capital Epiphysis (See Slipped)

Gallbladder (See Agenesis of)

Gastric Polypectomy. Case Report of Removal Via the Fiberoptic Endoscope (Philip Edlin) 557

Golt's Syndrome. A Case Report (Annemarie Sommer; Antoinette P. Eaton; and Stella B. Kontras) 721

Hematuria (See Bongo Drum)

Heroin Maintenance Clinics. A Discussion of the U.S. Addiction Treatment and the "British System" (David G. Logan) 165

Hydrothorax Complicating Subclavian Vein Infusion Therapy. A Case Report (Stewart P. Chase) 106

Intestinal Cancer in the Peutz-Jeghers Syndrome. A Re-evaluation (John D. Reid and Mary Petrelli) 231

In Vitro Thrombosis in Acute Myocardial Infarction (Donald E. Yochem and Darrell E. Roach) 419

Knee, Rheumatoid (See Evaluation of McKeever Tibial Plateau)

Larynx (See A New Look at)

Lavage, Peritoneal (See Diagnostic)

Lead Encephalopathy. Report of a Case Associated with Industrial Exposure (Miguel A. Pedraza and Frank Anzinger) 319

Lecithin (See Clinical Value of)

Letters to the Editor 321

Maternal Health in Ohio:

Maternal Deaths Due to Stroke 172

Maternal Deaths Associated With Appendicitis 377

Maternal Mortality Report for Ohio—1971 563

Maternal Cases Involving Carcinoma of the Cervix..... 726

Medical Education:

Medical Education Workshops. A Study of Their Influence on Teaching Behavior of Medical College Faculty (William C. Farr and Mary Heider) 102

Myocardial Infarction (See In Vitro Thrombosis in)

Nephrology Page:

When the Serum Sodium Is Low (Leonard B. Berman) 111

Neuromas, Acoustic (See Early Diagnosis and Management of)

Nontoxic Edema of Pregnancy (Melvern A. Ayers) 239

Pancreas (See Papillary Cystadenocarcinoma)

Pancreatic Pseudocysts. A Brief Review with Emphasis on Radiological Aspects (Emil Gutman; F. P. Sarathi; and Jerome F. Wiot) 495

Papillary Cystadenocarcinoma of the Pancreas (Joseph L. Bilton; Nadir D. Saddawi; Krishna P. Saigal; and Madhira D. Ram) 236

Paternity Testing (See Pitfalls in)

Peritoneal Lavage (See Diagnostic)

Peutz-Jeghers Syndrome (See Intestinal Cancer in)

Physician Assistants in Ohio (See Problems and Prospects for)

(continued)
Pitfalls in Paternity Testing (John W. King; Geneva E. Cylar; and Muriel J. Bartley) 724
Polypectomy (See Gastric)
Pregnancy (See Nontoxic Edema of)
Prevention of Pruritus Ani (Leon Goldman) 425
Problems and Prospects for Physician Assistants in Ohio (J. S. Gravenstein, et al) 95
Pruritus Ani (See Prevention of)
Pseudocysts (See Pancreatic)
Pulmonary Angiography as an Aid to Resectability in Bronchogenic Carcinoma (F. L. Mendez, Jr.; Owen L. Brown; and R. C. Rooney 665
Sensitivity of Intermediate-Strength Purified Protein Derivative in Active Tuberculosis. Comparison of Stabilized and Nonstabilized Preparations (Juan A. Simon) 368
Sickle Cell Abnormalities (See Awareness of)
Slipped Femoral Capital Epiphysis (David K. Halley) 628
Sphingomyelin (See Clinical Value of Lecithin and)
Squamous Cell Carcinoma of the Conjunctiva (John D. Bullock; Daniel M. Albert; and Stephen J. Richman) 502
Tenosynovitis (See Thermographic Demonstration of)
Thermographic Demonstration of Tenosynovitis. A Case Report (Roger B. Traycoff; Kenneth M. Malin; Keith L. Ewing; and Bernard J. Rubal) 632
Thrombosis (See In Vitro)
Treatment of Operable Carcinoma of the Breast by Modified Radical Mastectomy (Edward Woliver; Edward H. Saeks; Ronald H. Fegelman; and Joel Korelitz) 500
Tuberculosis (See Sensitivity of Intermediate-Strength Purified Protein)

AUTHORS OF CLINICAL AND SCIENTIFIC PAPERS AND CASE RECORDS

Albert, Daniel M. (New Haven, Conn.) 502
Anzinger, Frank (Springfield) 319
Ayers, Melvern A. (Toledo) 108, 239

Barnes, Arthur (Cleveland) 95
Bartley Muriel J. (Atlanta) 724
Berman, Leonard B. (Cleveland) 111
Bhakthavathsalan, Amrutha (Toledo) 108
Bilton, Joseph L. (deceased) 236
Brown, Henry W. (Cleveland) 630
Brown, Owen L. (Cincinnati) 665
Bullock, John D. (Menlo Park, Calif.) 502

Cafferata, H. Treat (Reno, Nevada) 671
Chase, Stewart P. (Columbus) 106
Cook, William A. (Akron) 625
Cordero, L. (Columbus) 35
Cylar, Geneva E. (Cleveland) 724

Damoulaki-Sfakianaki, E. (Columbus) 35
DePiero, Nicholas (Cleveland) 95
DeWalt, C. (Columbus) 35

Eaton, Antoinette P. (Columbus) 721
Edlin, Philip (Cincinnati) 557
Ewing, Keith L. (Kent) 632

Farr, William C. (Tucson, Ariz.) 102
Fegelman, Ronald H. (Cincinnati) 500
Freiberg, Richard A. (Cincinnati) 316

Goldman, Leon (Cincinnati) 425
Gravenstein, J. S. (Cleveland) 95
Gutman, Emil (Dayton) 495

Halley, David K. (Lancaster, England) 628
Hatfield, Glenn E. (Columbus) 38
Heider, Mary (Cincinnati) 102
Houser, Harold B. (Cleveland) 27

Jackson, Edgar B., Jr. (Cleveland) 27

Katz, Sidney (Cleveland) 95
King, John W. (Cleveland) 724
Klein, Harold C. (Cleveland) 31
Kontras, Stella B. (Columbus) 721
Korelitz, Joel (Cincinnati) 500
Kovaks. Steven (Cleveland) 95
Kreindler, Michael S. (Columbus) 421
Kretchmer, Henry (Cleveland) 95

LaVoo, John H. (Nellis Air Force Base, Nev.) 313
Logan, David G. (Cleveland) 165

Macpherson, C. R. (Columbus) 35
Malin, Kenneth M. (Columbus) 632
Martin, Gerhard E. (Columbus) 98
Mayfield, Frank H. (Cincinnati) 365
Mehbod, Hassan (Dayton) 169
Mendez, F. L., Jr. (Cincinnati) 665
Miglets, Andrew W., Jr. (Columbus) 37, 101, 171

Nicolas, Elias M. (Cleveland) 630

Pedraza, Miguel A. (Springfield) 319, 559
Peters, Joseph (Cleveland) 27
Petrelli, Mary (Cleveland) 231
Potter, Kenneth (Cleveland) 95

Ram, Madhira D. (Cleveland) 236, 630
Reid, John D. (Cleveland) 231
Rhotan, Frances (Cleveland) 95
Richman, Stephen J. (Barrington, R.I.) 502
Roach, Darrell E. (Columbus) 419
Rooney, R. C. (Cincinnati) 665
Ruhal, Bernard J. (Houston, Tex.) 632

Saddawi, Nadir D. (Cleveland) 236
Saeks, Edward H. (Cincinnati) 500
Saigal, Krishna P. (Cleveland) 236
Sankey, B. B. (Cleveland) 95
Saranthi, F. P. (Dayton) 495
Schiller, William R. (Toledo) 313
Seidensticker, John F. (Columbus) 38
Shapiro, Ivan L. (Columbus) 671
Simon, Juan A. (Dayton) 368
Sommer, Annemarie (Columbus) 721

Tennenbaum, James I. (Columbus) 421
Tew, John M., Jr. (Cincinnati) 365
Traycoff, Roger B. (Kent) 632

Viljoen, John (Cleveland) 95
von Haam, Emmerich (Columbus) 38

Welch, Paul W. (Canton) 316
Wiet, Richard J. (Cincinnati) 365
Wiot, Jerome F. (Cincinnati) 495
Woliver, Edward (Cincinnati) 500

Yates, William T. (Akron) 625
Yochem, Donald E. (Columbus) 419
Young, William I. (Cleveland) 27

GENERAL INDEX

Advertising Classified—67, 139, 203, 286, 345, 397, 481, 533, 591, 641, 705, 771
Notice of Change in Rates for Classified Advertisements, 67

Advertising Index—66, 138, 202, 285, 344, 396, 480, 532, 590, 640, 704, 770

American Medical Association—
Report of AMA Clinical Convention, 117; Coaches Turn to AMA for Coaching, Facing Page 193; AMA to Air "Today's Health" Programs, 210; Health Insurance Claim Form Prepared by AMA, 215; Dr. Sammons to Be AMA Executive Vice-President, 290; AMA Ohio Delegation Meeting, 334; AMA Annual Convention Set in Chicago, 362; AMA Grants to Medical Schools Reach New Peak, 379; U.S. Adds 9,845 Physicians, 472; Welcome to Portland, 491; Report of Actions Taken at the 1974 AMA Convention, 506; New Society (Association of American Volunteer Physicians) Will Boost Voluntarism by Physicians, 562; AMA Inaugurates Medical Scholarships, 583; AMA Clinical Convention in Portland Promises Excellent Features, 634; Business before AMA House of Delegates at the 1974 Clinical Convention, 752

American Medical Political Action Committee—(See Ohio Medical PAC)

American Medical Association Education and Research Foundation (AMA-ERF)—
AMA Inaugurates Medical Scholarships, 583; Doctor Your Generous Contribution Is a Solid in Medicine Future, 678

Annual Meeting of OSMA—131, 180, 251
Hotel Reservation Page 58; Scientific Exhibits Wanted, 59, 754; Plans Show High Points of 1974 Annual Meeting, 126; Six Postgraduate Courses Among Features, 190; OSMA's Olde But Goode Night, 193, 266; Run for Your Life, 195; Annual Meeting Brochure Wins Top Honors, 198; Annual Meeting Features, 252; Athletic Team Physicians to Be Honored by Exhibit at Annual Meeting, 334; Message from the President: OSMA Annual Meeting, 338; Reports on the 1974 Annual Meeting, 431-465; Annual Meeting Attendance, 464; Awards Given at Physicians' Art Show, 636

Apparatus—(See Pharmaceuticals, Apparatus and Related Products)

Art—
Art Show Planned for OSMA Annual Meeting, 54, 129, 196, 264, 636

Associations, Societies and Organizations: Local and State—

Associations, Societies and Organizations: Regional, National and International—
Industrial Medical Association Changes Name to "American Occupational Medical Association," 540

Authors of Special Articles and Articles in the Professional Activities Section—
James E. Pohlman, LL.B., Developments in the Law: the Physician and the Minor Patient, 4; John H. Ackerman, M.D., Community Health Column (see index under Ohio Department of Health); Robert C. Waltz, M.D., Improving Emergency Medical Service in Ohio, 72; Robert R. Clark, M.D., and Paul Y. Ertel, M.D., Medical Advances Institute, 292; Howard D. Sirak, M.D., and Stanley W. Olson, M.D., Does Ohio Need More Medical Education Facilities? 404; James K. Skipper, Ph.D., Jack L. Mulligan, M.D., Mohan L. Garg, Sc.D., and Michael J. McNamara, M.D., Peer Group Review, an Educational Experience, 488

Book Reviews—(See Physician's Bookshelf)

Building—
New OSMA Headquarters (see Ohio State Medical Association)

Classified Ads, see **Advertising, Classified**—

Community Health News—(See Ohio Department of Health)

Continuing Medical Education—(See also Medical Education)
Keeping Up: Continuing Medical Education Opportunities for Physicians in Ohio—14, 90, 149, 226, 342, 392, 414, 526, 546, 602, 660, 713

The Council—
Proceedings of Nov. 3-4, 1973 Meeting, 46; Proceedings of Dec. 15-16, 1973 Meeting, 121; Letter of Protest Regarding Medicare and Medicaid Patients, Insert Following Page 132; In This Issue of The Journal You'll Find Some Innovations, 175; Proceedings of Jan. 19-20 Meeting, 177; Increase in Dues Recommended by The Council, 186; The Cost of Getting the Job Done, 241; Candidate for the Office of President-Elect (Dr. Maurice Lieber), 243; OSMA Budget for 1974, 282; Proceedings of March 9-10 Meeting, 323; OSMA Committees at Work, 332; Uterine Cancer Project Receives OSMA Endorsement, 332; Message from the President on Annual Meeting, 338; Officers Elected at Annual Meeting, 380; Proceedings of April 6 Meeting, 381; Members of The Council Elected, 432; The President's Address, 435; Proceedings of May 16 Meeting, 463; Roster of Association Officers and Committeemen, 477; Proceedings of July 27-28, 1974 Meeting, 571; Approves Definition of the Physician's Assistant in Ohio, 577; Proceedings of the Council, September 20-22, 1974 Meeting, 674

County Medical Societies—
Executive Director (James Imboden) Named by Columbus Academy, 281; Roster of County Society Officers and Meeting Dates, 474; Scioto County PG Seminar Scheduled for Oct. 24, 616

Deaths—(See Obituaries)

Disability Determination—(See Social Security)

Distinguished Service Citation—
Citation for Distinguished Service to Medicine Presented to John H. Budd, M.D., 462

Drugs—(See also Pharmaceuticals)
How to Prepare for an Investigation by the Drug Enforcement Administration, 88

Emergency Service—
Improving Emergency Medical Service in Ohio, 72; Attorney General's Opinion Regarding DOA Patient, 206; Organization of Emergency Medical Services Councils, 352

Environmental and Public Health—(See Ohio Department of Health)

Ethics—
Contributing Patients' Names to Mailing Lists Is Illegal, 400

Exhibits—(See also Annual Meeting)
Scientific Exhibits Wanted for OSMA Annual Meeting, 128

Family Practice—
Family Practice Director Named at Ohio State, 288; 24th Annual Scientific Assembly of Ohio Academy of Family Physicians Announced, 408; Ohio Academy of Family Physicians Names Officers For The Year, 611; Residents of Cleveland, Youngstown receive OSMA Family Practice Scholarships, 729

Field Services—
Introducing OSMA's Expanded Field Service and Its Newly Appointed Director (Robert Holcomb), 583

Financial Report, OSMA and The Journal—
Report on Examination of Financial Statements for the Year Ended December 31, 1973, 648

Food and Drug Administration—(See Pharmaceuticals)

Golf—
Ohio State Medical Golfers Association holds Tournament at Canton, 514

Governor's Task Force on Health—
Minority Report, Insert after page 192

Headquarters—
New Headquarters of OSMA (See Ohio State Medical Association)

Health—
Minority Report to the Report of the Governor's Task Force on Health, Insert After Page 192

Historian's Notebook—(and Other Items of Historical Interest) Medical-Science Historians to Meet in Columbus, 134; "An Old Country Doctor" (featuring Dr. William Eberle Thompson), 548

Hospitals—
Opinion of Attorney General Regarding DOA Patient, 206; Joint Commission on Accreditation of Hospitals Releases Reports, 290; Cleveland Clinic to Share in CHD Long-Range Study, 308; Cincinnati General Participates in Surgery-Anesthesia Studies, 389; Continuing Education Network Accepting Hospitals for 1975 Programs, 747

House of Delegates, OSMA—
Provisions in OSMA Bylaws Pertaining to Nomination of President-Elect, 50; Deadline for Submission of Resolutions, 137, 158; Increase in Association Dues Recommended, 186; Ohio Places Last in Dues Survey, 189; Cost of Getting the Job Done, 241; Candidate for the Office of President-Elect (Dr. Maurice Lieber), 243; House of Delegates Agenda, 267; Reference Committees, 268; Roster of Members of House, 270; Resolutions Submitted for Consideration, 277; Officers and AMA Delegates Elected at Annual Meeting, 380; Index to Resolutions, 440; Proceedings of the House, 1974 Annual Meeting, 442; Attendance of Delegates, 460; Citation for Distinguished Service (Dr. John Budd), 462; Woman's Auxiliary Report to the House, 466; Roster of Association Officers and Committeemen, 477

Industrial Commission—(See Workmen's Compensation)

Insurance—
Now Open Enrollment, OSMA Sponsored Disability Income Protection Plan, 71; OSMA Term Insurance Plan Dividend Declared; Disability Plan Opened, 185; Health Insurance Claim Forms, 215; Group Insurance Administrator Opens Cleveland Office, 472; OSMA Legal Counsel Testifies on Malpractice Insurance, 656

The Journal—
In This Issue of The Journal You'll Find Some Innovations, A message from the President, 175; Your Journal Is a Bit Thin, Doctor, 235; It Isn't the Paper Shortage, Doctor, 395; News Editor, (Jan Tanner) Named to Staff of Ohio State Medical Journal, 637; Consulting Medical Editor Named 753; Executive Editor Retires after 26 yrs., 755

Laws, Legislation and Court Decisions—
Developments in the Law: The Physician and the Minor Patient, 4; Opinion of Attorney General Regarding DOA Patient, 206; Ohio's New Workmen's Compensation Law and How It Works, 410; State Medical Board's Position on Administrative Due Process, 513; Actions of Medical Interest by the Ohio General Assembly, 518

Letters to the Editor—
Regarding Little League Sports, 18

Laboratories—
Is Your Office Lab Proficient, Doctor? Proficiency Evaluation Program, 146

Licensure—(See State Medical Board of Ohio)

Maternal Health—(See Index to Clinical and Scientific Papers)

MDs in the News—13, 134, 302, 701
Columbus Physician Dr. Frances K. Harding, Receives Elizabeth Blackwell Award, 142; Findlay Gains Ten Physicians, 358; Dr. Russell C. Long, Trying to Build Modern Hospital in Haiti 545; "An Old Country Doctor," featuring Dr. William Eberle Thompson, 548; Dr. Reiheld Cited For Rural Health Work, 692; Dr. Petznick Is Head of AMA Judicial Council, 690

Medical Advances Institute (MAI)—
OSMA Staff Member (Herbert Gillen) Accepts Post with MAI, 57; Medical Advances Institute (a Discussion of Its Purposes and Direction), 292; The Impact of A Computerized Peer Review System, Continuing Medical Education, 748

Medical Assistants—
Medical Assistants Certified Through National Examination, 644; Laura Lockhart Elected National President, 679

Medical Colleges—see **Medical Education and Medical Colleges**

Medical Education and Medical Colleges—(See also Continuing Medical Education)
Portrait of Dr. Meiling Is Gift of Faculty to College of Medicine, 51; Medical Education Workshops, 102; Chicago Physician (Dr. Zuspan) to Head Ob-Gyn Service at OSU, 244; Federal Funds Again Requested for OSU Medical Center Expansion, 28; Family Practice Director Named at OSU, 288; Cincinnati Medical College Cornerstone Laying Scheduled, 356; AMA Grants to Medical Schools Reach New Peak, 379; Does Ohio Need More Medical Education Facilities? 404; Progress Climaxed with Groundbreaking at Wright State University, 484; All Health Sciences Programs at OSU Put Under New Vice-Presidency, 536; U. of Cincinnati Vice-President and Medical Center Director Named, 536; Cincinnati Medical College Dedication Scheduled, 570; Cincinnati Medical College To Dedicate Its New Home, 594; Cincinnati U. Establishes Family Practice Dept., 698; Additions to Medical Profession Reach All-Time High, 699; OSU Names New Chairman For Dept. of Surgery, 700; Univ. of Cincinnati, Names Acting Head of New Family Practice Dept., 708; Wright State Med School Gains Two Dept. Chairmen, 759; OSU To Review Criteria For Admitting Students, 764

Medicare, Medicaid—
Letter of Protest Regarding Medicare and Medicaid Patients, Insert Following Page 132: Medicaid — How to Submit Error-Free Claims Forms, 156

Members, Roster of New OSMA—83, 285, 296, 384, 540, 662, 718

Minors—
Developments in the Law: The Physician and the Minor Patient, 4

Newborn Workshops—(See Ohio Department of Health)

News Media—(See Public Relations)

Obituaries—60, 130, 160, 223, 311, 386, 468, 522, 584, 614, 696, 758

Ohio Department of Health—
Community Health News—Gonorrhea Testing, 43; Measles (Rubeola) Reporting, 43; Use of the Health Laboratories, 148; Influenza and Reye's Syndrome, 219; Hemophilia, 219; Gonorrhea Control, 360; Reye's Syndrome, 360; Clostridium Perfringens Food Poisoning, 360; Treatment Schedule for Gonorrhea, 486; Back to School Nuisance Diseases, 646; Health Director Lays Groundwork for Hemophilia Program in Ohio, 142; Traveling Newborn Workshops Open to Ohio Physicians, 212; Immunization Action Month, 542; Pap Test Program Expanded, 542; Malaria, 596; Influenza Vaccination, 596; Meningococcal Disease in Ohio, 710

Ohio Medical Indemnity—
OMI Highlights of 1973 Operations, 304; OMI Maintains High Place Among Blue Shield Plans, 516

Ohio Medical Political Action Committee (OMPAC)—
"But My Few Dollars" Promotion Page 20; Support for OMPAC-AMPAC Vital This Election Year, 340; Politics and Medicine Must Mix, 393; Reasons Why You Should Join OMPAC, 441; How Would You Like to Work for the Government, 524; The Same Hat Doesn't Fit Everyone, 763

Ohio State Medical Association—(See also Council, House of Delegates, etc.)—
OSMA Headquarters Offices Going Up, 52; New Member (Douglas Houser) Joins OSMA Executive Staff, 57; OSMA Staff Member (Herbert Gillen) Accepts Post with MAI, 57; Ribbon-Cutting Ceremonies Held for OSMA Headquarters Building, 390; OSMA Executive Director (Hart F. Page) Named to Board of American Society of Association Executives, 550; Introducing OSMA's Expanded Field Service and Its Newly Appointed Director (Robert Holcomb), 583; News Editor (Jan Tanner) Named to Staff of Ohio State Medical Journal, 637; Douglas Houser, OSMA Staff Member, Elected to American Association of Medical Society Executives, 679; Brent Mulgrew Appointed as New OSMA Staff Member, 685; OSMA President and Health Director Confer, 689; Former OSMA President (Dr. Petznick) Is Head of AMA Judicial Council, 690; Ohio Physician (Dr. Riehld) Cited For Rural Health Work, 692; Notice to All Members Concerning Dues, 711; Executive Editor, (R. Gordon Moore) Retires, 755

Page, Hart F. (Executive Director, OSMA)—
Named to Board of American Society of Association Executives, 550

Peer Review—
Peer Group Review; an Educational Experience, 488

Pharmaceuticals, Apparatus and Related Products—
How to Prepare for an Investigation by the Drug Enforcement Administration, 88; New Standards Scheduled for X-Ray Equipment, 348; Speed-Up Urged in Approving

Physician Recognition—OSMA Continuing Medical Education, Physician Recognition Program, 731

Physicians's Assistants—
Problems and Prospects for Physician Assistants in Ohio, 95; Definition of the Physician's Assistant in Ohio Is Approved by the OSMA Council, 577;

Physician's Bookshelf—
Current Medical Diagnosis and Treatment, 160; Applications of the Laser, 212

Postgraduate Activities—(See Continuing Medical Education)—

Prescriptions—(See Pharmaceuticals)—

Professional Standards Review—(See Peer Review)

Public Health—(See Ohio Department of Health)

Public Relations—
Findlay Gains Ten Physicians as Reported in Local Newspaper, 358;

Research—(See also Medical Education)
Battelle Gets Contract to Study Anticancer Drugs, 348; Cincinnati Cholesterol Study to Run for Seven Years, 515; Progress Reported in University Hospitals of Cleveland Cystic Fibrosis Study, 548; OSU Gets Major Regional Cancer Research Center, 583

Resolutions—(See House of Delegates)—

(continued)

(continued)

Rural Health—
27th National Rural Health Conference Scheduled in Detroit, 242

Safety—
Traffic Fatalities Down in Ohio, 206; "Know Your Limit" Slogan Highlights New Tact on Safety, 400

Scholarships—
Two More Worthy Medical Students Sought for OSMA Family Practice Scholarships, 246

Scientific Exhibits—(See Exhibits)

Social Security—
What is SSI (Supplemental Security Income—Title XVI) All About? 208

Specialties and Specialty Societies—
College of American Pathologists Sponsor Proficiency Evaluation Program (PEP), 146; Maternal Health Committee Celebrates 20th Anniversary, 198; Traveling Newborn Workshops, 212; Lions Eye Research Funds, 285

Sports Medicine—
Sports Medicine Conference at Newark High School Stresses Health and Safety of Scholastic Athletes, 176; Athletic Team Physicians to Be Honored by Exhibit at 1974 OSMA Annual Meeting, 334

State Board of Pharmacy of Ohio—(See Pharmaceuticals)

State Medical Board of Ohio—
Enforcement Actions for the Year Reported by State Medical Board, 153; Toledo Physician (Dr. Roland A. Gandy, Jr.) Named to State Medical Board, 336; Contributing Patients' Names to Mailing Lists Is Illegal, 400; Board's Position on Administrative Due Process, 513

Supplemental Security Income (SSI)—See Social Security

Taxation—
IRS Revises Ruling Concerning Deductible Travel Expenses, 552

Travel Tours—
Orient Adventure Announced, 349; Mediterranean Adventure, 401; African Adventure, 606

Veterans Administration—
Hemodialysis Center for Cincinnati VA Hospital, 18; VA Reports Figures on Health Care, 133

Woman's Auxiliary—
Woman's Auxiliary Highlights—62, 135, 200, 284, 341, 388, 470, 528, 586, 639, 702, 760
Woman's Auxiliary Report to the OSMA House of Delegates, 466; Report of Auxiliary Annual Meeting, 470

Workmen's Compensation—
Ohio's New Workmen's Compensation Law and How It Works, 410

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Burroughs Wellcome Co. 715

Daniels-Head & Associates, Inc. 759

Dorsey Laboratories, Div. of Sandoz-Wander, Inc. 709, 757, 761

Harding Hospital 712

Lilly, Eli and Company 720

The Medical Protective Co. 747

Pharmaceutical Manufacturers Association 716, 717

Roche Laboratories, Div. of Hoffman-LaRoche, Inc. .....Inside Front Cover, 707, Inside Back Cover, Back Cover

Wm. H. Rorer, Inc. 730

Schmidt's Sausage Haus 760

Turner & Shepard, Inc. 764

University Center 762

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